PRINTED: 06/10/2011

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155723 05/17/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3001 GALAXY DR RIVER POINTE HEALTH CAMPUS **EVANSVILLE, IN47715** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F0000 The submission of this plan of F0000 This visit was for a Recertification, correction does not indicate an State Licensure, and State admission by RIver Pointe Health Campus that the findings and Residential Licensure Survey. allegations contined herein are an accurate and true representation Survey dates: May 9, 10, 11, 12, 13, of the quality of care and services provided to the residents of River 16, 17, 2011 Pointe Health Campus. This facility recognizes it's obligation to provide legally and medically Facility number: 002280 necessary care and servies to it's Provider number: 155723 residents in an economic and efficient manner. The facility Aim number: N/A hereby maintains it is in substantial compliance with the Survey Team: requirements of participation for comprehensive health care Diane Hancock, RN, TC facilities.(for Title 18/19 Martha Saull, RN programs) To this end, this plan of correction shall serve as the Amy Wininger, RN credible allegation of compliance with all state and federal requirements govrning the Census bed type: management of this facility. It is SNF. 52 thus submitted as a matter of statute only. Residential: 40 Total: 92 Census payor type: Medicare: 31 Other: 61 92 Total: Sample: 13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

4Q0D11

Facility ID:

PRINTED: 06/10/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMP	LETED		
		155723	B. WING		05/17/2	2011		
NAME OF I	PROVIDER OR SUPPLIE	FR.		ADDRESS, CITY, STATE, ZIP CODE				
I WHILE OF I	THO VIDER OR SOLLED			SALAXY DR				
RIVER P	RIVER POINTE HEALTH CAMPUS			EVANSVILLE, IN47715				
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECT	ION	(X5)		
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO		COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE		
	Supplementa	l sample: 9						
	Residential S	ample: 7						
		1						
	These deficie	encies also reflect state						
	findings cited	l in accordance with						
	410 IAC 16.2	2.						
	Quality review con Cathy Emswiller F	-						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4Q0D11

Facility ID: 002280

If continuation sheet

Page 2 of 107

PRETIX TAG REGULATORY OR I.SC IDENTIFYING INFORMATION) FO15.7 SS=D Acadility must immediately inform the resident conditions or discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment), or a specified in §483.12(a). The facility must trecord and periodically update the address and phone number of the resident sangle representative or interested family member when there is a nexified of high blood pressures, for 1 of 1 supplemental sample resident observed with high blood pressures during the medication pass, in		T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/17/2011
RIVER POINTE HEALTH CAMPUS IXA9 ID SUMMARY STATEMENT OF DEPICIENCIES TAG RECULATORY OR LSC IDENTIFYING INFORMATION) A facility must immediately inform the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in \$483.12(a). The facility must also promptly notify the resident as specified in \$483.12(a). The facility must also promptly notify the resident as specified in \$483.15(e)(2); or a change in resident fights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, interview and record review, the facility failed to ensure the physician was notified of high blood pressures, for 1 of 1 supplemental sample resident observed with high blood pressures during the medication pass, in	NAME OF P	ROVIDER OR SUPPLIER				
TAG REGULATORY OR LOCATION ON THE PRECEDED BY FULL TAG REGULATORY OR LOCATION ON THE PRECEDED BY FULL TAG A facility must immediately inform the resident, consult with the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also prompty notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(c)(2); or a change in room or roommate assignment as specified in \$483.15(c)(2); or a change in room or roommate assignment as specified in \$483.15(c)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, interview and record review, the facility failed to ensure the physician was notified of high blood pressures have been review. An order has been weritten for B/P paragrees and guidelines to notify the physician.	RIVER P	OINTE HEALTH CA	MPUS	l l		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A facility must immediately inform the resident; physician; and if known, notify the resident's physician; and if known, notify the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(a)(z); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, interview and record review, the facility failed to ensure the physician was notified of high blood pressures, for I of I supplemental sample resident observed with high blood pressures during the medication pass, in				1		(X5)
F0157 SS=D A facility must immediately inform the resident, consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, interview and record review, the facility failed to ensure the physician was notified of high blood pressures, for 1 of 1 supplemental sample resident observed with high blood pressures during the medication pass, in		`		1	CROSS-REFERENCED TO THE APPROPRIAT	
a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, interview and record review, the facility failed to ensure the physician was notified of high blood pressures, for 1 of 1 supplemental sample resident observed with high blood pressures during the medication pass, in	TAG F0157	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate		1	CROSS-REFERENCED TO THE APPROPRIAT	TE COMPLETION DATE
family member. Based on observation, interview and record review, the facility failed to ensure the physician was notified of high blood pressures, for 1 of 1 supplemental sample resident observed with high blood pressures during the medication pass, in F0157 F 157 Resident 62 has been seen by the physician and his blood pressures have been review. An order has been written for B/P parameters and guidelines to notify the physician.		State law or regular paragraph (b)(1) of the facility must resupdate the address	ations as specified in of this section. ecord and periodically s and phone number of the			
record review, the facility failed to ensure the physician was notified of high blood pressures, for 1 of 1 supplemental sample resident observed with high blood pressures during the medication pass, in Resident 62 has been seen by the physician and his blood pressures have been review. An order has been written for B/P parameters and guidelines to notify the physician.						
the physician was notified of high blood pressures, for 1 of 1 supplemental sample resident observed with high blood pressures during the medication pass, in Resident 62 has been seen by the physician and his blood pressures have been review. An order has been written for B/P parameters and guidelines to notify the physician.			·	F0157	F 157	06/10/2011
the supplemental sample of 9. (Resident #62) All other residents have the potential		the physician wa pressures, for 1 or resident observed pressures during the supplemental	s notified of high blood of 1 supplemental sample d with high blood the medication pass, in		physician and his blood pressur have been review. An order has written for B/P parameters and guidelines to notify the physicia Completion Date 6-10-2011	es been an.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/17/2011	
RIVER P	PROVIDER OR SUPPLIER		STREET 3001 (ADDRESS, CITY, STATE, ZIP CODE GALAXY DR SVILLE, IN47715	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL L SC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE
TAG	Finding includes During the media 9:05 a.m., RN #1 Resident #62's belectronic blood blood pressure we pulse was read a RN #1 proceeded medication to the medications for late time. On 5/12/11 at 10 clinical record we pressure log india 5/11/11 0500 [5: pressure] 182/10 5/11/11 0915 [9: 93 There was no incompressures had be physician. The high blood processor with the Director [DoHS] and Min 5/12/11 at 10:53	cation pass, on 5/12/11 at a laws observed to check lood pressure using an pressure machine. The ras read at 168/115. The tay 22 beats per minute. It to administer the resident, including high blood pressure at a reviewed. A blood cated the following: 100 a.m.] BP [blood 8, Pulse 134 a.m.] BP 159/109, P 15 a.m.] BP 168/115, P 15 a.m.] BP 168/115, P 16 dication the blood en reported to the coressures were reviewed at of Health Services atmum Data Set nurse, on a.m. The DoHS	TAG	CROSS-REFERENCED TO THE APPROPR	ns in I red dure for nes. al neters cian random ician onth n I to QA ns and
		ident's physician had a er, and she [the Nurse			

l	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY IPLETED 7/2011
	PROVIDER OR SUPPLIER		3001 G	ADDRESS, CITY, STATE, ZIP (ALAXY DR VILLE, IN47715	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	_	in the building and the resident. "We'll get				
	5/12/11, the DoF reported she chec early the first mo pressure medicat blood pressure at reported the 9:00 taken after therap increased blood p When the blood 5/12/11 at 9:15 a	at 11:22 a.m. on IS indicated the RN had eked the blood pressure brining, gave the blood ions and rechecked the 19:00 a.m. The RN I a.m. blood pressure was by, so she associated the pressure with the activity. pressure was taken on .m., she indicated it was well; she did not notify				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155723	B. WING			05/17/2	011
			D. WII		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ALAXY DR		
RIVER P	OINTE HEALTH CA	MPUS			VILLE, IN47715		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0280 SS=E	incompetent or oth incapacitated under participate in plant changes in care at A comprehensive	care plan must be					
	of the comprehens by an interdisciplir attending physicia responsibility for the appropriate staff in by the resident's in practicable, the partice resident's family representative; and revised by a team each assessment.						
Based on interview and record review, the facility failed to ensure residents were able to participate in care planning, in that 4 of 7 residents who would have had quarterly care plan conferences did not have quarterly care plan conferences, in a sample of 14. (Residents #1, #35, #63, #49) Findings include: 1. During initial tour, on 05/09/11 at 9:50 A.M., Resident #63 was identified by the DoHS [Director of Health Services] as interviewable.		F0280	F 280 Resident # 1, 35, 63, and 49 suffered no ill effects from the deficient practice. Care plan conferences have been held for the above residents. Completion Date 6-10-2011 All residents have the potential to be affected by the deficient practice and through alterations in processes and in servicing will ensure residents are able to participate in care planning and the campus will conduct quarterly care plan conferences. Completion Date 6-10-2011		06/10/2011		
		rd of resident #63 was 1/11 at 4:30 P.M.			The interdisciplinary team memhave been in serviced on the procedure for quarterly care pla conferences. Systemic change is	n	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 05/17 /2	LETED
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	at 11:00 A.M., R sitting in her sco	o interview, on 05/11/11 esident #63 was observed oter and was queried if ortunity to participate in		tracking system has been to assure care conferences completed timely. Completion Date 6-10-20	are	
	that she was not held care plan m The most recent Set Assessment].	MDS [Minimum Data		ED/designee is to audit the residents to assure care contains a recompleted quarterly 5 for a month then 3x a weed month then weekly with reforwarded to QA committed to the committed for review and further suggestions/comments	onferences x a week kk for a esults ee monthly	
	The clinical reco	rd indicated Resident #63 08/26/10.			Completion Date 6-10-2011	
		cked any documentation neeting had been held.				
	08/26/10, indicate welcomed resident this day and visite [Resident] stated and was hopeful	Progress note, dated ted, "SS [Social Service] ent back from the hospital ted with her. Res. I she was glad to be back to return to AL [Assisted te she was stronger"				
	provided by the S Designee], on 05 and was identified when she [Resid	dated 05/16/10, was SSD [Social Service 5/12/11 at 11:50 A.M., ed by the SSD as "from ent #63] was on Assisted rvice Plan was signed by				

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE COMPI	LETED
		155723	B. WINC	·		05/17/2	2011
	PROVIDER OR SUPPLIER			3001 GA	DDRESS, CITY, STATE, ZIP CODE ALAXY DR VILLE, IN47715	-	
					VILLE, IN477 13		1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	1 -	05/16/10 and signed by aughter on 06/26/10.					
	In an interview with the SSD, on 05/12/11						
	at 10:40 A.M., sl was her own resp	ne indicated Resident #63 ponsible party.					
	at 11:50 A.M., sł	with the SSD, on 05/12/11 ne indicated the Service					
	had the family si	ut on 05/16/10 and she gn it on 06/26/10 and that nference has been held					
	ı						
		rd of Resident #35 was 1/11 at 10:30 A.M.					
		MDS assessment, dated ed the resident had ve impairment.					
	The clinical reco	rd indicated Resident #35 01/21/11.					
		cked any documentation neeting had been held.					
		Progress Note, dated ed, "Resident transferred					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	TED
		155723	B. WIN			05/17/201	1
NAME OF I	PROVIDER OR SUPPLIER	<u>L</u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SOLI EIER				ALAXY DR		
RIVER P	OINTE HEALTH CA	MPUS		EVANS	VILLE, IN47715		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		[certified area] from					
	[facility] assisted	l living [unit]."					
		'4 4 CCD 05/10/11					
	In an interview with the SSD, on 05/12/11						
	at 11:55 A.M., she indicated, "No care						
	plan meeting was held."						
	3. During initial tour, on 05/09/11 at						
	10:10 A.M., Resident #64 was identified						
	by the DoHS as interviewable. The clinical record of Resident #64 was reviewed on 05/11/11 at 11:40 A.M.						
	l reviewed on 03/1	11/11 at 11.40 A.M.					
	The most recent	MDS assessment, dated					
		ed the resident had no					
	cognitive impair						
	cognitive impairi	ment.					
	The clinical reco	rd indicated Resident#					
		tted to the facility on					
	11/09/10.	tied to the facility on					
	11/05/10.						
	The Care Plan la	cked any documentation					
		neeting had been held.					
	p.m						
	In an interview w	vith Resident #64, on					
		P.M., he indicated he					
		nvited to a care plan					
	meeting.	Programme Programme					
	In an interview with the SSD, on 05/12/11						
		e indicated no care plan					
		held since Resident #64					
	_	facility in November."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 05/17/2	LETED	
	PROVIDER OR SUPPLIER		3001 G	ADDRESS, CITY, STATE, ZIP CO ALAXY DR VILLE, IN47715	ODE	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	4. During initial	tour, on 05/09/11 at 9:35 #49 was identified by the				
	The clinical record of Resident #49 was reviewed on 05/12/11 at 3:25 P.M.					
		MDS assessment, dated ted the resident had impairment.				
		ord indicated Resident #49 the facility on 01/17/06.				
	1	cked any documentation conference had been held.				
	at 11:25 A.M., si hasn't been a car	with the SSD, on 05/12/11 the indicated, "There e conference held for nt #49] since I came here				
	at 8:30 A.M., she Services staff "w care conferences different times	with the SSD, on 05/12/11 e indicated the Social vere weak at that [holding of], We meet with family at We have to get on top of o keep up with the regs				
		with the SSD, on 05/12/11 he indicated, "We have so				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723			(X2) MULTIPLE CC A. BUILDING B. WING	00		E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER		STREET A 3001 G.	ADDRESS, CITY, STATE, ZIP C ALAXY DR VILLE, IN47715	CODE	
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	care conference, would run the bu good system of the fallen through the supposed to hold quarterly." The policy and p First Meeting Guthe SSD, on 05/1 indicated, "Purpocommunication replan of care, meeting of the second properties of the second plan of care, meeting the second plan of care, meet	rocedure for Resident aidelines was provided by 2/11 at 11:50 A.M., and use: To facilitate regarding the resident's lical condition, and care are resident, family, and care re:2. should be				
F0282 SS=D	facility must be pro	ded or arranged by the ovided by qualified persons neach resident's written				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155723 05/17/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3001 GALAXY DR RIVER POINTE HEALTH CAMPUS **EVANSVILLE, IN47715** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
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CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F0282 06/10/2011 Based on observation, interview, Resident # 1, 35, 63, and 49 suffered and record review, the facility no ill effects from the deficient failed to ensure the plan of care was practice. Care plan conferences have been held for the above residents. followed, for 2 of 6 sampled **Completion Date 6-10-2011** residents with histories of falls, in the total sample of 13, and 1 of 1 All residents have the potential to be supplemental sample resident affected by the deficient practice and observed during the medication through alterations in processes and in servicing will ensure residents are pass, in the supplemental sample of able to participate in care planning 9, in that the care plans for fall and the campus will conduct quarterly care plan conferences. prevention were not followed for 2 Completion Date 6-10-2011 residents and the written orders for medications were not followed for The interdisciplinary team members 1. (Residents #35, #3, #62) have been in serviced on the procedure for quarterly care plan conferences. Systemic change is a Findings include: tracking system has been put in place to assure care conferences are 1. During initial tour, on 05/09/11 completed timely. Completion Date 6-10-2011 at 10:00 A.M., Resident #35 was identified by the DoHS [Director of Health Services] as not ED/designee is to audit three random interviewable and having a history residents to assure care conferences of falls. Resident #35 was observed are completed quarterly 5x a week for a month then 3x a week for a at that time sitting in a wheelchair month then weekly with results in the hallway across from the forwarded to OA committee monthly nursing station with a clip alarm. x6 months and quarterly thereafter for review and further suggestions/comments The clinical record of Resident #35 Completion Date 6-10-2011 was reviewed on 05/11/11 at 10:30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		E SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		PLETED
		155723	B. WIN	IG		05/17/	/2011
NAME OF I	PROVIDER OR SUPPLIE	3		STREET A	ADDRESS, CITY, STATE, ZIP COD	3	
					ALAXY DR		
RIVERP	OINTE HEALTH C	AMPUS		EVANS	VILLE, IN47715		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT ACTION OF CORRECT ACT		(X5)
PREFIX TAG	· `	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
IAG		cated Resident #35		IAU			DATE
	had a history of falls and dementia.						
	The most recent MDS [Minimum						
	Data Set Asse	ssment], dated					
	04/22/11, indi	cated Resident #35					
	1	te impairment of					
	cognitive function.						
	The CNA [Certified Nursing						
		•					
	_	signment Sheet,					
	^ *	ne DoHS on 05/09/11					
	at 9:45 A.M. a	and last updated					
	05/02/11, indi	cated Resident #35					
	was a fall risk	, required a clip alarm					
		d a pressure alarm to					
	the bed and ch	-					
	the bed and ci	1411.					
	A Cana Dlan f	an Calla - daka d					
	A Care Plan fo						
	· ·	cated Resident #35					
	1	of fall and was at risk					
	for falls. The	Fall Care Plan					
	included, but	was not limited to,					
		of "2/22/11 Clip					
		at all times3/5/11					
		n to bed and chair."					
	i icssuit aiaili	ii to ocu anu chan.					
	The NI	-4 1-4-104/00/11					
		otes, dated 04/09/11					
	at 1800 [6:00	P.M.], indicated,					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION 00	(X3) DATE S COMPL	
		155723	A. BUI B. WIN	LDING IG		05/17/2	011
NAME OF F	PROVIDER OR SUPPLIER		_		ADDRESS, CITY, STATE, ZIP CODE ALAXY DR		
RIVER P	OINTE HEALTH CA	MPUS		1	VILLE, IN47715		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	"Resident four	nd lying on floor in					
	bathroom with shirt off. Assisted to						
	w/c [wheelcha	ir]resident states					
	he removed his	s clip alarm then took					
	his shirt off, at	tempted to get in the					
		st balance et [and]					
	fellPressure alarm placed to w/c						
	[wheelchair]. Resident instructed						
	on fall prevention compliance with						
	alarms."						
	A Fall Circum	stance, Assessment,					
	and Intervention						
		cated Resident #35					
	ĺ	r removing his clip					
	alarm.						
	In an interview	with the DoHS, on					
	05/11/11 at 12	:00 P.M., she					
	indicated that	clip alarms and					
	pressure alarm	s were both ordered					
	for Resident #3	35. She further					
		Resident #35 was					
		ove the clip alarm and					
	_	arm would activate if					
	_	o get out of the chair.					
		ther indicated that					
	_	ut a pressure alarm in					
	Resident #35's	chair prior to the fall					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	CC	DATE SURVEY DMPLETED 17/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 GALAXY DR EVANSVILLE, IN47715					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
TAG	on 04/09/11, so the clip alarm did not alert st further indicat alarm was not wheelchair bed failed to be taken and placed on Nursing Assist sheet. The Do interventions was appropriate if place." 2. During init at 10:05 A.M., identified by the	o when he removed the pressure alarm aff. The DoHS ed that the pressure		TAG	DEFICIENCY)		DATE	
	on 05/10/11 at The Admission Data Assessme indicated Resi cognitive impa	n MDS [Minimum ent] dated 05/03/11 dent #3 had moderate						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
ANDILAN	or connection	155723	A. BUI		00	05/17/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ALAXY DR		
RIVER P	OINTE HEALTH CA	MPUS		EVANS	VILLE, IN47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		was not limited to, a					BIIIE
	ĺ	lzheimer's Dementia					
		ing memory]. The					
	Physician's Re	cap further indicated,					
	"[name of sitte	er service] to provide					
	sitting services	s from 6 P.M. to 6					
	A.M. (sundow	ning increase)"					
	A Care Plan fo	or falls, dated					
	04/28/11, indic	cated Resident #3					
	was a risk for	falls and included,					
	but was not lin	nited to,					
	interventions	.5/5/11in direct					
	line supervisio	on if up in wheelchair					
	and sitter not v	with him5/8/11					
	every 15 minu	te checks til [sic]					
	6:00 A.M. then	n continue direct line					
	supervision wl	hen up in					
	wheelchair."	-					
	The CNA [Cer	tified Nursing					
	Assistant] Ass	ignment Sheet,					
	provided by th	e DoHS on 05/09/11					
	at 9:45 A.M. a	nd last updated					
	05/02/11, indic	cated Resident #3					
	was a fall risk,	and required a					
	pressure alarm	to the bed and chair.					
	The Nurse's N	otes, dated 05/07/11					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MULT A. BUILDI B. WING		NSTRUCTION 00	(X3) DATE S COMPL 05/17/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 GALAXY DR EVANSVILLE, IN47715					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
		P.M.], indicated,					J.II.S	
	"Alarms heard	, staff entered room						
	immediately et observed Resident							
	attempting to							
	alarm mat and	turn off the alarm.						
	Resident non-	compliant with using						
	call light, gets	up without notice"						
	The Nurse's Notes, dated 05/07/11							
	at 2000 [8:00 P.M.], indicated,							
	"Staff sees res	ident walking down						
	hallway towar	d unit doors, no						
	alarms soundi	ng-shut off by						
	resident. Seni	or Helper sitter not						
	here tonight, u	nable to get another						
	senior helper s	staff inContacted						
	daughterto u	pdate her on						
	situation. Stat	es she cannot come						
	in tonight. Mo	onitoring."						
		otes, dated 05/08/11						
	at 0100 [1:00]	A.M.], indicated,						
	"Res. [residen	t] alarm sounding.						
	Upon entering	room res noted to be						
	-	e bed turning alarm						
		res on importance of						
	asking for assi	st. Expressed						
	understanding	but was again						
	turning alarm	off before staff could						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMP 05/17/2	LETED	
	PROVIDER OR SUPPLIEF		3001 (ADDRESS, CITY, STATE, ZIP CO GALAXY DR SVILLE, IN47715	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
IAG	get in the room dated 05/08/11 and indicated, sounding-is not fall mat beside if he fell or sa. The Fall Circu Investigation, indicated, "Redirect line-up. The Fall Circu Investigation, indicated Resident experiencing at the time of with direct line with sitter or in the staff left he slid out of the DoHS further.	m. The next entry was at 1 at 0300 [3:00 A.M.] "Res alarm ow sitting in floor on the bed. Unable to state that on floor" Instance dated 05/05/11, s. will be supervised in w/c [wheelchair]." Instance dated 05/08/11, dent #3 was agitation/restlessness the fall and "continue the supervision if not in bed." In which with the DoHS, on				DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MULTIPLE (A. BUILDING B. WING	00	COM	te survey IPLETED 7/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 GALAXY DR EVANSVILLE, IN47715					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	"The sitter from in and there we wish it had been differentthey sundowner's started 15 min no documentar monitoring him called me so we himIf the sitt show up we has supervision." A Nursing men DoHS on 05/1 indicated, "DHS on 05/1 indicated, "DHS services] show following situations/incident are of an urange of the start of the situations of the situation	m the agency called as no replacementI en done know he has probably should have ute checksthere is tion that we were mthey should have the could supervise ter agency does not have to provide mo provided by the 1/11 at 4:00 P.M. IS [Director of Health had be notified of the dentsStaffing issues argent nature" 9:05 a.m., RN #1 was stering medications to the administered 7 [seven] in pill form. The		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE			
	5/12/11 at 9:33 a orders. The resid on 5/10/11. Adm orders, dated 5/1	I record was reviewed, on .m., regarding medication dent had been admitted hission medication 0/11, included, but were e following: Gliburide						

Facility ID:

li i		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155723	B. WING		05/17/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
RIVER P	OINTE HEALTH CA	MPUS		ALAXY DR VILLE, IN47715	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		[mg] [medication for mes daily before meals.			
	_	Gliburide was not			
		w of the Medication			
	•	Record [MAR], on			
		.m., indicated the			
		t been included on the			
	record, therefore				
	The omission of	the glyburide for 2 days			
		th the Director of Health			
	Services, on 5/12	2/11 at 10:53 a.m. She			
	indicated the ord	er had not been			
	transcribed from	the admission orders at			
	the time of admis	ssion; the omission had			
	been corrected.				
	3.1-35(g)(2)				
	(8)()				
F0323		ensure that the resident lins as free of accident			
SS=E		sible; and each resident			
	receives adequate	e supervision and assistance			
	devices to prevent		F0222	E 222	06/10/2011
	A. Based on o	,	F0323	F 323	06/10/2011
	interview, and	record review, the		Resident 35 and Resident 3 plan	n of
	facility failed	to ensure 2 of 6		care related to risk for falls has	been
	residents with	a history of falls, in		reviewed and updated as necess and staff has been in serviced o	•
		14, were provided		plan of care.	ii uiis
	_	supervision to		The pilot light on the stove has	been
			<u> </u>	l	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155723	B. WIN			05/17/2011
NAME OF I	PROVIDER OR SUPPLIER	₹		1	DDRESS, CITY, STATE, ZIP CODE	
DIVED B	OINTE HEALTH O	MDUS			ALAXY DR VILLE, IN47715	
	OINTE HEALTH CA			L	VILLE, IN47713	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
1710		·		1710	reviewed by GCS.	DATE
	l *	ents, in that Resident			Completion Date 6-10-2011	
	#35 was not provided a pressure					
	alarm and exp	erienced a fall and			All other residents are at risk to	
	Resident #3 w	as not provided			affected by the alleged deficient and through alterations in proce	· •
	supervision ar	nd experienced a fall.			and in servicing the campus wil	II
		r			ensure that the resident environ	
	R Racad on abo	servation, interview and			remains as free of accident haza	
					as is possible; and each resident	
		ne facility failed to ensure s were observed in the			receives adequate supervision a	nd
	1 - 1				assistance devices to prevent accidents.	
	lighting of a gas	alfunctioning pilot light,			Completion Date 6-10-2011	
	1	n observations. This had			•	
	_	affect 52 residents residing			Nursing staff have been in servi	l l
	in the facility.				concerning Fall/Safety Manager Systemic change is the C.N.A.	ment.
					Assignment sheet that commun	icates
	Findings inclu	ıde:			to the C.N.A. fall and safety	
					interventions will be updated	
	A1. During in	nitial tour, on			immediately after a new interve	ntion
	05/09/11 at 10	0:00 A.M., Resident			is put in place. Dietary Staff have been in servi	ced
		ified by the DoHS			on lighting the pilot light per	
		.			manufactures guidelines. Syste	II
	l =	[ealth Services] as not			change is all dietary employees	II
		and having a history			complete competency on lighting pilot light now and annually	ng the
		dent #35 was observed			thereafter.	
	at that time sit	ting in a wheelchair			Completion Date 6-10-2011	
		across from the				
	1	n with a clip alarm.				
		a man a viip aiaiiii.				
	The aliminat	and of Doni 1 4 H2F				
		ecord of Resident #35				
		on 05/11/11 at 10:30				
	A.M., and ind	icated Resident #35			DHS /designee will monitor 3	4-
					random resident at risk for falls	to

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723		A. BUILDING B. WING	G	00	(X3) DATE : COMPL 05/17/2	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 GALAXY DR EVANSVILLE, IN47715				
(X4) ID PREFIX TAG	The most rece Data Set Asse 04/22/11, indi had a moderat cognitive fund. The CNA [Ce Assistant] Ass provided by that 9:45 A.M. a 05/02/11, indi was a fall risk to the bed, and the bed and ch. A Care Plan for 02/10/11, indi had a history or risk for falls. included, but interventions a larm to bed a Pressure alarm. An additional cognitive imposition.	ent MDS [Minimum ssment], dated cated Resident #35 re impairment of etion. Triffied Nursing signment Sheet, he DoHS on 05/09/11 and last updated cated Resident #35, required a clip alarm d a pressure alarm to hair. The Fall Care Plan was not limited to, of "2/22/11 Clip at all times3/5/11 in to bed and chair."	TA ID PREI	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY) assure safety interventions in p per plan of care and staff follow plan of care to prevent an accide a week for a month then 3x a w for a month then weekly with r forwarded to QA committee m x 6 months and quarterly therefor review and further suggestions/comments ED/designee will quiz one rand dietary employee on how to lig pilot light 5x a week for a month the weekly with results forwarded committee monthly x 6 months quarterly thereafter for review further suggestions/comments	lace as ving lent 5x /eek esults onthly after lom the ento QA s and	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/17/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 GALAXY DR EVANSVILLE, IN47715					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
	recall problem indicated Resi problems under [related to] derinterventions is limited to, "conchecks." The Nurse's not at 1800 [6:00] "Resident four bathroom with w/c [wheelchar he removed his shirt off, at shower and lost fellPressure [wheelchair]. on fall prevent alarms." A Fall Circum and Intervention 04/09/11, indicated fallen after alarm.	erstanding others r/t mentia. The ncluded, but were not nduct regular safety otes, dated 04/09/11 P.M.], indicated, nd lying on floor in a shirt off. Assisted to ir]resident states s clip alarm then took tempted to get in the st balance et [and] alarm placed to w/c Resident instructed tion compliance with						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 05/17/2	LETED	
NAME OF F	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE	1 30/11/2	
RIVER P	OINTE HEALTH CA	MPUS		1	VILLE, IN47715		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	05/11/11 at 12	:00 P.M., she					
	indicated that	clip alarms and					
	pressure alarm	as were both ordered					
	for Resident #	35. She further					
	indicated that	Resident #35 was					
		ove the clip alarm and					
	_	arm would activate if					
	_	o get out of the chair.					
		ther indicated that					
	staff had not put a pressure alarm in						
		chair prior to the fall					
	on 04/09/11, s	o when he removed					
	* '	the pressure alarm					
	did not alert st	aff. The DoHS					
	further indicat	ed that the pressure					
	alarm was not	-					
		cause the intervention					
		ken from the care plan					
	•	the CNA [Certified					
	Nursing Assist	tant] assignment					
		oHS indicated, "The					
	interventions v	would have been					
	appropriate if	they had been in					
	place."						
	A2. During in						
		:05 A.M., Resident					
		ied by the DoHS as					
	not interviewa	ble and having a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPLE		
ANDILAN	OF CORRECTION	155723	A. BUII			05/17/20	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER			1	ALAXY DR		
RIVER P	OINTE HEALTH CA	MPUS		EVANS	VILLE, IN47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	history of falls).					
	, , , , , , , , , , , , , , , , , , , ,						
	The clinical record was reviewed						
	on 05/10/11 at	11:00 A.M.					
	The Admission	n MDS [Minimum					
	Data Set Asses	ssment], dated					
	05/03/11, indic	cated Resident #3 had					
	moderate cogn	nitive impairment.					
		_					
	The May 2011	Physician's Recap					
	included, but v	was not limited to, a					
	diagnosis of A	lzheimer's Dementia					
	[disease affect	ing memory]. The					
	Physician's Re	cap further indicated,					
	"[name of sitte	er service] to provide					
		s from 6 P.M. to 6					
	-	ning increase)"					
	A Care Plan fo	or falls, dated					
	04/28/11, indic	cated Resident #3					
	was a risk for i	falls and included,					
	but was not lin	nited to,					
	interventions	.5/5/11in direct					
	line supervisio	on if up in wheelchair					
	_	with him5/8/11					
	every 15 minu	te checks til [sic]					
	6:00 A.M. then continue direct line						
	supervision wh	hen up in					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 05/17/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ALAXY DR VILLE, IN47715		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	wheelchair."						
	provided by the at 9:45 A.M. at 05/02/11, indice was a fall risk, pressure alarm. The Nurse's N at 1900 [7:00] "Alarms heard immediately extempting to salarm mat and Resident non-call light, gets The Nurse's N at 2000 [8:00] "Staff sees reshallway towar alarms sounding resident. Senithere tonight, under the same sounding resident.	ignment Sheet, le DoHS on 05/09/11 and last updated cated Resident #3 and required a a to the bed and chair. otes, dated 05/07/11 P.M.], indicated, l, staff entered room at observed Resident step over pressure turn off the alarm. compliant with using up without notice" otes, dated 05/07/11 P.M.], indicated, ident walking down d unit doors, no					
	daughterto u						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMP		
		155723	A. BUI B. WIN	LDING IG		05/17/2	2011
NAME OF I	PROVIDER OR SUPPLIER		D. WII.	_	DDRESS, CITY, STATE, ZIP CODE		
				1	ALAXY DR		
	OINTE HEALTH CA			<u> </u>	VILLE, IN47715		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
	in tonight. Mo	onitoring."					
	The Nurse's N	otes, dated 05/08/11					
	at 0100 [1:00.	A.M.], indicated,					
	"Res. [residen	t] alarm sounding.					
	Upon entering	room res noted to be					
	_	e bed turning alarm					
		res on importance of					
	asking for assi	_					
	understanding but was again						
	_	off before staff could					
	_	n. The next entry was					
		1 at 0300 [3:00 A.M.]					
	and indicated,						
	•	ow sitting in floor on					
		e bed. Unable to state					
	if he fell or sat	t on floor"					
	The Fall Circu						
		dated 05/05/11,					
		s. will be supervised					
	direct line-up	in w/c [wheelchair]."					
	The Fall Circu	umstanaa					
	indicated Resi	dated 05/08/11,					
		gitation/restlessness the fall and "continue					
	with direct line	e supervision if not					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		A. BUII	LDING	NSTRUCTION 00	COM	TE SURVEY MPLETED 7/2011	
NAME OF PROVIDER OR SUPPLIER RIVER POINTE HEALTH CAMPUS			B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ALAXY DR VILLE, IN47715		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	05/11/11 at 2:3	w with the DoHS, on					
	05/05/11 related "taken to his retail the staff left his	ed to the resident was soom after lunch and m unattended and he wheelchair." The					
	#3 had a fall o	indicated, Resident n 05/07/11 related to, m the agency called as no replacementI					
	in and there was no replacementI wish it had been done differentthey know he has sundowner'sprobably should have started 15 minute checksthere is						
	monitoring hir called me so w	tion that we were mthey should have ye could supervise ter agency does not					
	show up we has supervision."	ave to provide					
	DoHS on 05/1 indicated, "DF	mo provided by the 1/11 at 4:00 P.M. IS [Director of Health lld be notified of the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMP 05/17/2	LETED	
NAME OF PROVIDER OR SUPPLIER RIVER POINTE HEALTH CAMPUS			<i>p.</i> wiiv	STREET A	DDRESS, CITY, STATE, ZIP CODE ALAXY DR VILLE, IN47715	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE
TAG	situations/incide that are of an upper into the area then carried the lattchen in an area on 5/11/11 at 11 observed to again paper, kneel down the oven a paper, tried to ligurous of the served to roll upper lattchen and lattchen in an area of the served to again paper, kneel down the oven a paper, tried to ligurous on 5/11/11 at 12 observed to roll upper lattchen and	dentsStaffing issues argent nature" 1:10 P.M., Cook #2 was g by the oven. He took a rehment type paper, g cone shaped manner and from the gas stove top. down on the floor, banel (which extended the nof the oven), located door, pushed in a button and then stuck the lit has under the stove. He it paper to the back of the habelind a wall. 1:40 A.M., Cook #2 was a roll up parchment type m, open the small panel door, push the button and then, with the lit		TAG			DATE
		35 P.M., Cook #2 was indicated that the cooks					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMP 05/17/2	LETED	
	PROVIDER OR SUPPLIER		3001 G	ADDRESS, CITY, STATE, ZIP CO ALAXY DR VILLE, IN47715	DDE	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF	OULD BE	(X5) COMPLETION
TAG	don't have to light oven every day. light has not bee about 2 months. sometimes the pindicated there at the oven pilot light lift the oven rack from inside the other front panel led door. Cook #2 is showed him how parchment paper. He indicated Cobutton to the pilot prime the line windicated they have used on a grill) but to reach the pilot using the lit parce the paper to the strunning water becomes a considerable with the paper to the strunning water becomes a considerable with the pilot light not light rolling the light not light considerable. The pilot light not light considerable with the pilot light not light pilot light not light li	Int the pilot light to the He indicated the pilot in working on and off for Cook #2 indicated filot light goes out. He are different ways to light ght. He indicated you can as up and light the pilot oven down and /or open ocated below the oven indicated Cook #1 had to use the rolled to reach the pilot light. To the head of the pilot light for 30 seconds to get he wasn't long enough at light. He indicated after shment paper, they take sink and put it under effore disposing of it. 188 P.M. a copy of the quest, dated 4/22/11, was Administrator. The ed as the kitchen, and the nocouple needs cleaned. Shting." Remarks: couple pilot light working the provided a copy of the RR] provided a copy of	TAG	DEFICIENCY)		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4Q0D11

Facility ID:

002280

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	e survey ipleted '/2011	
	PROVIDER OR SUPPLIER		3001 G	ADDRESS, CITY, STATE, ZIP (SALAXY DR SVILLE, IN47715	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	oven. This form included, but wa following inform pilot of an oven, oven thermostat door, remove ow to expose pilot at panel and depressafety valve, light On 5/11/11 at 4:: interviewed. He to the oven was a call was placed company) last we the problem was the door to kitch vacuum and the indicated the overwas an ongoing was first made at week. He indicated the light On 5/11/11 at 5 I interviewed. He rolled up piece of the best way to for oven was being I on 5/12/11 at 3 I provided a work	eek. The RR indicated a combination of when en is open it creates a pilot light goes out. He en needs new jets and it problem. He indicated he ware of this problem last ted the maintenance man t. P.M., the RR was indicated that using a f parchment paper "isn't ly" regarding the way the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155723	B. WING		05/17/2011
NAME OF F	PROVIDER OR SUPPLIER		l	ALAXY DR	
RIVER P	OINTE HEALTH CA	MPUS	I	VILLE, IN47715	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE DATE
		5/12/11. The form			
	identified the following description: "Pil	lowing problem ot won't stay lit" for the			
	•	vice performed included			
	the following: "5				
	*	n name) problem is cks at this time show all			
		nance man name) to let			
	,	ing else develops."			
	3 1 45(a)(1)				
	3.1-45(a)(1) 3.1-45(a)(2)				
E0222	The facility must o	nsure that residents are			
F0333 SS=G		ant medication errors.			
		review and interview, the	F0333	F 333	06/10/2011
	=	ensure it was free of eation errors, for 1 of 1		Resident # 62's medication	
	•	nple resident reviewed		orders have been reviewed b	y the
	for medications,	in the supplemental		primary physician. Completion Date 6-10-2011	
	-	nat the new admission		Compiction Date 0-10-2011	
		ceive Lasix [diuretic] eceived it three times a		All residents have the potent	ial to
	,			An residents have the potent	141 W

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MULTIPI A. BUILDING		00	(X3) DATE SURVEY COMPLETED 05/17/2011	
	PROVIDER OR SUPPLIER		300	01 GAI	DRESS, CITY, STATE, ZIP CODE LAXY DR LLE, IN47715	00/11/2011
RIVER P (X4) ID PREFIX TAG	summary's (EACH DEFICIEN REGULATORY OR day, resulting in and then received potassium for tw Finding includes Resident #62's cl reviewed on 5/16 resident was adm 5/10/11 with diag limited to, conge severe pulmonary coronary artery of acute renal insuff cardiomyopathy, pulmonary disease Medication order included, but we	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) a low potassium level, d less than the ordered o days. (Resident #62)	I	ANSVI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) be affected by the alleged deficient practice and through altercations in processes and servicing the campus will ensure measures to prevent medications. Completion Date 6-10-2011 Nursing staff have been in serviced on medication order regarding passing medication and transcription of medication orders/lab orders. Systemic change is physician orders transcribed to the medication administration sheet will be reviewed by two nurses. All nurses and QMAs will compla medication pass competence now and annually thereafter. Completion Date 6-10-2011	n in sure on ss as on lette
	Record [MAR], of indicated the ord transcribed as "L [three times a day medication had be three times a day 5/14, 5/15, and of the physician's order indicated the control of the control	edication Administration on 5/16/11 at 10:55 a.m., er for Lasix had been asix 40 mg p.o. T.I.D. y] before meals." The seen documented as given on 5/11, 5/12, 5/13, nee thus far on 5/16/11.			DHS/designee will review ne admission orders in daily clim meeting to assure orders whe reviewed for accuracy 5x we one month 3x a week x one month then weekly with result forwarded to QA committee monthly x 6 months and quarthereafter for review and furth suggestions/comments	nical re cek x Its terly her
		[potassium chloride] 40 livalents] two times a day ort indicated the			Nurse managers will perform random audits of 2 nurses passing medication for 2 rand	

		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SI		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	05/17/20	
		155723	B. WIN			05/1//20	/ 1 1
NAME OF F	PROVIDER OR SUPPLIER				ALAXY DD		
RIVER POINTE HEALTH CAMPUS				1	ALAXY DR VILLE, IN47715		
	_				VILLE, IIV+77 10		77.0
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	resident's potassi	um level was 2.8 on			residents 5x week x one mor	nth	
	1 ^	mal ranges being			3x a week x one month then		
	· ·	v-up potassium level, on			weekly with results forwards	ed to	
	5/16/11, was note				QA committee monthly x 6		
	,				months and quarterly thereaf	ter	
	The error in trans	scription was reviewed			for review and further		
		n's Nurse Practitioner, on			suggestions/comments		
	1 1	a.m. She indicated the			Completion Date 6-10-2011	-	
		n more frequently than					
		ecount for the low					
		and indicated she was					
	unaware of the en						
	unaware of the ch	1101.					
	The Director of N	Nursing indicated, on					
		a.m., she would need to					
		s and the MAR. At 11:30					
		ed it did appear there was					
	1	r, she pointed out the					
	·	er had seen the resident					
		/11 and indicated to					
		e orders, including the					
	Lasix 40 mg thre						
		w waj.					
	According to the	Lippincott Manual of					
	ı	Handbook, third edition,					
	_	w potassium levels] can					
		retic therapy. Signs and					
	•	ookalemia included					
		gy, anorexia, abdominal					
		ased bowel sounds, and					
	· ·	ss. The manual indicated					
		alted more quickly with					
		rapy, such as furosemide					
	[Lasix].	137					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155723	A. BUI	LDING	00	05/17/20	
		155725	B. WIN			03/17/20	J11
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE ALAXY DR		
RIVER POINTE HEALTH CAMPUS				1	VILLE, IN47715		
			-		· · · · · · · · · · · · · · · · · · ·	ı	075)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	The Director of F	Health Services was					
		/16/11 at 3:00 p.m. She					
		cedure for reviewing new					
	_	for accuracy was the					
		se transcribes the orders					
		order sheet and signs it, a					
	1	iews the orders for					
		ns it, a nurse manager is					
	-	third check of the orders					
	1 ^ ^	this case, she indicated					
	l -	admissions that date.					
	LPN #2 took the						
		, LPN #3 [a nurse					
	manager] did the	_					
		ned off on them. RN #2					
		review the orders for					
		tional time. The Director					
	1	es indicated RN #2 noted					
		reviewed them and LPN					
		nanager, so she did not					
		vith her review, since a					
	I -	ad already reviewed					
	~	ated they were in the					
		ng at the process and					
	where it broke do	-					
	where it bloke de	SWII.					
	The Medication	Administration Record					
		ewed, regarding the					
		de, on 5/16/11 at 2:30					
	1 ^						
	_	the potassium chloride					
		e a day was started on					
		ing. the MAR indicated					
	two doses were g	given on 5/14 and two					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723		(X2) MU A. BUII B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 05/17/2	ETED	
	PROVIDER OR SUPPLIER			3001 GA	DDRESS, CITY, STATE, ZIP CODE ALAXY DR VILLE, IN47715	•	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	doses on 5/15 and Review of the man the pharmacy into on 5/13/11. The delivered of 20 mindicated two talk twice a day. The the time of the represent and indicated that the time of the represent and indicated that the time of the represent and indicated that morn should have been 40 meq each. Resident #62. This information Director of Health 5/16/11 at 3:00 puback up pharmac some doses and a p.m., she reported further evidence being provided, and the potassium half	d one dose on 5/16. edication provided from dicated it was delivered re were 30 tablets neq each. The label olets were to be given ere were 24 tablets left at eview. RN #1 was cated she had given two ing. Ten [10] tablets n missing for 5 doses of N #1 then checked the g Kit [EDK]. No doses of een signed out for I was reviewed with the th Services [DoHS] on o.m. She indicated the ey could have provided she would check. At 3:45 d they could find no of additional medication so he must have gotten m dose over the weekend, et a day instead of 40 meq					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155723	B. WING			05/17/2	011
			D. WINC		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ALAXY DR		
RIVER P	OINTE HEALTH CA	MPUS			VILLE, IN47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL	1	PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſΈ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	BEFELECTY		DATE
F0361 SS=F	either full-time, pa	mploy a qualified dietitian rt-time, or on a consultant					
	basis.						
	If a qualified dietiti	an is not employed full-time,					
		esignate a person to serve					
	as the director of f	ood service who receives					
		led consultation from a					
	qualified dietitian.						
	Δ qualified dietitian	n is one who is qualified					
	•	registration by the					
	•	etetic Registration of the					
		Association, or on the basis					
		ing, or experience in					
		etary needs, planning, and					
	implementation of		F0.	261	F 361		06/10/2011
		ation, interview and	FU.]	1 301		00/10/2011
		e facility failed to ensure			No resdients suffered any ill		
		qualified Food Service			effects from the feficient practic	e.	
		in attendance and/or					
	•	absence; the facility failed			All residents have the potential		
		ified designee to oversee			be affected by the deficient prac		
	the operations of	the kitchen for 42 of the			and through the designation of a qualified food service director,	1	
	50 days (from 3/s	9/11 to 5/17/11). This			sanitation and overall kitchen		
	had the potential	to affect 52 residents			operation will meet such		
	residing in the fa	cility.			requirements set forth by the Inc	diana	
	_	-			Department of Health.		
	Findings include	:			Completion Date 6-10-2011		
	<i>y</i>					I	
	On initial tour of	the kitchen, on 5/9/11 at			The new designated food service	20	
		#1 was interviewed. He			manager will be enrolled in the		
		M (food service manager)			required courses to meet the Inc		
		she was sick. At 11			State Department of Health		
					requirement for qualified food service manager. The designee will		
	·	vas again interviewed.					
		Cook #3 would be the			also receive training and orienta	ıtion	
	staff person to di	rect inquires to, as "she's			by the Divisional Home Office		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER				INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155723		LDING		05/17/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIER	1		1	ALAXY DR	
RIVER F	POINTE HEALTH CA	AMPUS		1	VILLE, IN47715	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG	•	LSC IDENTIFYING INFORMATION)	-	TAG		DATE
	the cook who ha	s been here the longest."			Support Food Service Staff. Completion date 6-10-2011	
	On 5/11/11 at 8:4	40 A.M., Cook #1 was			ED/Degianes will maniter	
	observed in the k	citchen. Cook #1			ED/Designee will monitor progression of course work onc	e
	indicated someti	mes they run out of eggs			a week until the requirement ha	I
	1	om the store. Cook #1			been met.	
	I -	gs purchased from the			Completion Date 6-10-2011	
	store were unpas	•				
	On 5/11/11 at 9	A.M., Cook #3 was				
		e indicated the FSM was				
		nospital and had been				
	1	onths. She indicated the				
	1 -					
		vas currently on medical				
	1	d been gone for 1 1/2				
	months.					
		25 A.M., Dishwasher #1				
	was interviewed					
	compartment sin	k. He indicated the first				
	1	papy water for soaking				
	items, the second	d sink was the rinse sink				
	and the third sinl	k is where staff filled				
	their buckets wit	h the sanitizing solution.				
	The first sink wa	s observed to have soapy				
	water in it with v	various cooking pans in it,				
	sticking up out o	f the water. The second				
	sink was also fill	led with clear water as				
	well as the third	sink, also filled with				
	1	hwasher #1 explained				
	1 -	r was dispensed by a hose				
		nected to a bottle of				
	1	ng the bottle of sanitizer				
	1	as there were dish racks				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723			(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE S COMPL 05/17/2	ETED
NAME OF I	PROVIDER OR SUPPLIEF	!	'		ALAXY DR		
RIVER P	OINTE HEALTH CA	AMPUS			VILLE, IN47715		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	Ē	(X5) COMPLETION DATE
	Dishwasher #1 v strength of the sa sink. He took the Phydration, and paper and stuck sink. He indicated strip in the water he removed the torange color as with the dispenser. Dust they "were lowed dispensing tubes wall, behind the empty metal hold indicated someons anitizing solution." On 5/11/11 at 11 interviewed. Should the clinical reviewed does nothing in the and no sanitation. On 5/11/11 at 3:0 toured with the Ferringerator on strong took #2 indicated plastic wrap. The	A.M., the Dietician was e indicated she only does was. She indicated she the kitchen, no tray lines					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLE	
AND PLAN	OF CORRECTION	155723	A. BUI	LDING	00	05/17/20	
		100720	B. WIN			03/11/20	, , , ,
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE ALAXY DR		
RIVER P	OINTE HEALTH CA	MPUS		1	VILLE, IN47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	On 5/12/11 at 4:1	5 P.M., the					
	Administrator pro	ovided copies of the					
	FSM (food service	ce manager) and the					
	AFSM (assistant	food service manager)					
	forms indicating	the times the staff were					
	off work.						
	On 5/16/11 at 10	A.M., a copy of the					
	facility contract a	agreement for the					
	Certified Dietitia	n with the facility was					
	received from the	e administrator. This					
	contract included	l, but was not limited to,					
	the following: ".	The facilities hereby					
	retains (name of	nutrition management					
	company) to prov	vide Nutrition					
	Management Ser	vicesinitial termtwo					
	year term beginn	ing on August 1, 2009					
	thru July 2011(Consultant dietician					
	servicesinclude	es the provision of					
	clinical nutrition,	, food service monitoring					
	and educational						
	programsMana	gement:Report					
	preparationSan	itation Review, Meal					
	Service Observat	ion"					
	On 5/16/11 at 11						
		as interviewed. She					
		oth the FSM and the					
		in the building, there					
		from 2 other buildings.					
		d the RR (regional					
	* ′	ad been here during that					
		dministrator indicated					
	during the time b	oth the FSM and AFSM					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE ST COMPLE	
THISTERN	or conduction	155723	A. BUI			05/17/20	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ALAXY DR		
RIVER P	OINTE HEALTH CA	MPUS			VILLE, IN47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		uilding, she did the					
		got help with the food					
	· -	SMs from other facilities.					
		en both the dietary					
	1 *	were gone, she would					
		ntact person for dietary					
		rith questions/concerns.					
		it no one person was					
		ay to day operations of					
	the dietary depar						
		dicated she was fulfilling					
	1 1	supervisory roll to the					
	best of her ability	ý.					
	On 5/16/11 at 1:3	22 D.M. tha					
		d RR were interviewed.					
	The Administrator						
		ook the cooks that she					
		ns and scheduled them in					
		e FSM. She indicated					
		e ordering of the food.					
		ner FSMs were available					
		ties and "probably 15					
	l ř	ed with other people out					
	_	he FSM and AFSM were					
	gone.						
	On 5/16/11 at 2:1	10 P.M., the					
		ovided documentation in					
	_	dars for the months of					
		May 2011 indicating the					
	_	The information					
		owing: The Food					
		(FSM) was out of the					
	Service ividinager	(1 DIVI) Was out of the					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723		LDING	NSTRUCTION 00		3) DATE SURVEY COMPLETED 05/17/2011	
	PROVIDER OR SUPPLIER		B. WIIV	STREET A	DDRESS, CITY, STATI ALAXY DR /ILLE, IN47715	E, ZIP CODE		
				<u> </u>	VILLE, IN477 13			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED	AN OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO	ON
	building from 3/3 3/28/11. The FS 4/4/11 and remain current date. The manager (AFSM 2/21/11 until 4/2 went on leave agremained off to the Regarding outside buildings in the confollowing coverate the calendars: For the RR (regional In April: FSMs whours on the following on the following on the body also in the body calendar, in FSM coverage: 5/12 and 5/16. On 5/17/11 at 9:24 Administrator was indicated the Cerbuilding 20 hour resident records recommendation company did not Dietitian to be reas kitchen sanital preparation, but the sident records are company did not preparation.	2/11 and returned on M was then gone from ned on leave to the e assistant food service (1) was on leave from 6/11. The AFSM then gain on 5/9/11 and the current date. He support from other dietary department, the ge was documented on for March: On 3/29/11, representative) was here; were in the building for 8 fowing dates: 3/14, 4/5, 4/14, 4/19, 4/21. The RR uilding on 4/7/11. The dicated the following for RR here 5/2, 5/4, 5/11, 20 A.M., the as interviewed. She retified Dietitian was in the sa week, reviewing and making clinical s. She indicated the ewant the Certified esponsible for issues such			CROSS-REFERENCED	TO THE APPROPRIATE		ON
FORM CMS-2	.567(02-99) Previous Version	ons Obsolete Event ID:	4Q0D11	Facility I	D: 002280	If continuation shee	et Page 42 of 10)7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED				
THE TERM OF CORNER	.1011	155723	A. BUIL			05/17/2	
NAME OF PROVIDER O	o ci iddi ied		B. WING		DDRESS, CITY, STATE, ZIP CODE		
					ALAXY DR		
RIVER POINTE HE	ALTH CA	MPUS		EVANS\	/ILLE, IN47715		
` ′ _		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
`		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
3.1-20(c		zoe izz.viii i iivo iiv oium miorvj	1				5.112
F0363 Menus m	nust meet	the nutritional needs of dance with the					
recomme and Nutr Council, prepared Based or record recipes of preparate observed recipe was revitable. Findings On 5/11 observed entree of indicated of meat gravy to observed out of a meat and	ended die ition Boar National A in advan n observateview, the were folkion for 1 d (5/11/1 as not us ewed, it d the pote is. I the pote is include a feef straight and added the pote of at this to containe d gravy.	tary allowances of the Food d of the National Research Academy of Sciences; be ce; and be followed. Action, interview and the facility failed to ensure the swed for food to f 1 meal preparation 1 noon meal), in that a seed and when the recipe thad not been followed. Sential to affect 52	F0	363	F 363 No resdients suffered any ill effects from the deficient practice. All residents have the potential be affected by the deficient practice and through the in-servicing and monitoring of the preparation of meals, recipes will be followed for each meal prepared. Completion Date 6-10-2011 All cooks will be in-serviced on recipe books and the importance of following recipes for the nutritional balance of meals for each resident. Completion Date 6-10-2011 FSM/Designee will monitor the preparation of meals to ensure recipes are being followed. Monitoring will take place 1 me per week for 1 month and then 1 meal 3x per week for 2 months.	to tice I	06/10/2011

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4Q0D11

Facility ID:

002280

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		A. BUI	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/17/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹		1	ALAXY DR		
RIVER P	OINTE HEALTH CA	AMPUS		EVANS'	VILLE, IN47715		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	I '	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
1710		. He indicated he added 4		mo	results being forwarded to QA		DATE
		n, out of a 5 lb container.			committee monthly x 6 months		
		bserved out in view for			quarterly thereafter for review a	ınd	
	1 ^	1:40 A.M., Cook #1 took			further suggestions and recommendations.		
	a bottle of "kitch	en Bouquet" and added			Completion Date 6-10-2011		
	several squirts to	the beef stroganoff pot.					
		measure the kitchen					
	1 ^	#1 indicated the beef					
	1 ~	ded the following					
		f, onion, gravy, sour					
	cream and the ki	tchen bouquet.					
	On 5/12/11 at 11	:30 A.M., a copy of the					
		nd procedure "Left over					
		lized in an appropriate					
		to aid in controlling					
	waste," was rece	eived from the Regional					
	Representative [RR]. The procedure					
	included, but wa	s not limited to, the					
		ipes should be followed					
		riate amounts are prepared					
	to prevent overp	roduction and waste"					
	On 5/12/11 at 11	:30 A.M., the RR					
		of the recipe for the Beef					
	1 ^	h was prepared on					
	5/11/11. Ingredi	ents included the					
	following: "Bee	f tenderloinunsalted					
		ed mushrooms, Spanish					
	onions, dill weed						
		g wine and lite sour					
	cream."						
	On 5/16/11 at 3	P.M., the RR (regional					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/17/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 GALAXY DR EVANSVILLE, IN47715					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	indicated the coo beef stroganoff, meal, for 100 ser beef stroganoff in	nds of beef tenderloin						
F0368 SS=E	provides at least the times comparable community. There must be no between a substantial breakfast the follow provided below. The facility must on the facility fac	eives and the facility hree meals daily, at regular to normal mealtimes in the more than 14 hours hital evening meal and wing day, except as ffer snacks at bedtime daily. If snack is provided at hours may elapse between hours may elapse between hing meal and breakfast the resident group agrees to this nourishing snack is served. The wand record review, the ensure residents were the snack, in that 7 of 7 the residents confidentially high the group interview,	F0368	F 368 Resident # 54, 55, 56, 57, 58, 61, suffered no ill effects from alleged deficient practice. Completion Date 6-10-2011				
	and 2 of 3 sampl	ed individual interviews,		All other residents have the po	tential			

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155723	B. WIN	IG		05/17/2	011
NAME OF	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER			3001 G	ALAXY DR		
	POINTE HEALTH CA				VILLE, IN47715		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)	-	TAG	,		DATE
	1 ^	13, indicated they were			to be affected by the deficient practice and through alterations	in	
	not offered bedti	me snacks. (Residents			processes and in servicing will	5 111	
	#53, #54, #55, #	56, #57, #58, #59, #60,			ensure the campus offers snacks	s at	
	#61)				bedtime daily.	S ut	
					Completion Date 6-10-2011		
	Findings include	•			·		
		-			Dietary and Nursing staff have	been	
	In a confidential	group interview,			in serviced related to offering s	nacks	
	1				at bedtime. Systemic change is		
	1	/10/11 at 11:00 A.M.,			nursing will initial when dietary	ý	
		54, #55, #56, #57, #58,			delivers the snacks		
	and #59 indicate	d the facility did not offer			Completion Date 6-10-2011		
	evening snacks.						
					DHS/designee will ask 3 randor	m	
	In a confidential	interview with Resident			alert and oriented residents if th		
	#61. on 05/10/01	at 9:45 A.M., she			were offered a snack the evening	-	
	1	nacks in the evening"			prior 5x a week for a month the	-	
	marcatea, 110 si	nacks in the evening			week for a month then weekly	with	
	In a confidential	interview with Resident			results forwarded to QA commi		
	1				monthly x 6 months and quarter	-	
	1	at 1:20 P.M., he			thereafter for review and furthe	r	
	1	not receive an evening or			suggestions/comments.		
	bedtime snack.				Completion Date 6-10-2011		
	.	14 0274 114 0274 114					
	1	with CNA #1, on 05/11/11					
		e indicated there was a					
	basket of snacks	at the nursing station if					
	the residents was	nted something.					
	A Policy for "Gu	idelines for Between					
	I -	rovided by the DoHS on					
	05/11/11 at 4:00						
		ovide for nutrition					
	1 -						
		Procedure:7.) Ask the					
	1	e wishes to be served a					
	snack"						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723			(X2) MU A. BUII B. WING	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/17/2	ETED
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE ALAXY DR VILLE, IN47715		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F0371 SS=F	O5/11/11 at 4:00 provided policy visuacks. 3.1-21(e) The facility must - (1) Procure food friconsidered satisfal local authorities; a (2) Store, prepare, under sanitary cornider sanitary cornidered satisfal local authorities; a consistency of the sanitation solution kitchen dishwash consistently main levels; foods were and labeled and/of to facility proceed eggs when not the monitor refrigeral maintain the kitch and/or ensure all non-dietary staff restraints when in food preparation of the same consistency of the same consiste	distribute and serve food ditions ation, interview and e facility failed to ensure in was at adequate levels; her temperatures were attained at adequate e stored covered, dated for disposed of according ture; serve pasteurized oroughly cooked; tor/freezer temperatures; hen in a sanitary manner;	F0	371	F 371 No residents suffered any ill effects from the deficient practic. All residents have the potential be affected by the deficient pract and through the in-servicing of and alterations of processes will ensure proper sanitation and food stora guidelines are being met. Completion Date 6-10-2011 All dietary staff have been in-serviced on the proper way to check sanitizer levels in their cleaning buckets as well as the accompartment sink.	tto ettice staff ge	06/10/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155723 05/17/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3001 GALAXY DR RIVER POINTE HEALTH CAMPUS **EVANSVILLE, IN47715** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Dining Room, Main Dining Room, Health Completion Date 6-10-2011 Center Dining Room) FSM/Designee will monitor This deficient practice had the potential to sanitizing affect all 52 residents as this kitchen solution stock weekly x 12 weeks. prepared food for all the healthcare FSM/ Designee will also monitor sanitation cleaning buckets as well as residents. the sanitizer in the 3 compartment sink 2 times a day for 2 weeks and Findings include: then 1 time a day for 2 weeks. Random checking of sanitizing levels 1. Initial tour of the kitchen began on will be done by FSM/Designee for another 5 months. Results will be 5/9/11 at 9:20 A.M. Cook #1 was brought to QA monthly for review observed to take a cloth from the bucket and recommendations if needed. on the counter and wipe off the food prep Completion Date 6-10-2011 table. Cook #1 took the container of test strip paper, labeled "Phydration" and The dishwasher has been checked by the appropriate vendor to ensure the stuck the orange colored paper in the proper temperature can be bucket of solution being used. The paper maintained for sanitation of our was held in the solution under 5 seconds. dishes. When the test strip was removed, the **Completion Date 6-10-2011** color remained the same orange color as All dietary staff have been prior to the strip being placed in the in-serviced on the proper wash and solution. The result was read by Cook #1 rinse temperatures for the dish as 100 PPM (parts per million). He machine and who to call for indicated this bucket of solution had been assistance if temperatures are too poured 2 1/2 hours ago and the level of Completion Date 6-10-2011 sanitation solution should be between 100 and 200 PPM. The yellow pudding like substance that was unlabeled was thrown On 5/11/11 at 9:25 A.M., Dishwasher #1 away. The roast type ham in the refrigerator that was dated 5-5-2011 was interviewed regarding the 3 was also thrown away. The roast compartment sink. He indicated the first beef that was partially opened and sink contained soapy water for soaking unlabeled was thrown away. The items, the second sink was the rinse sink turkey that was opened and undated and the third sink is where staff filled was thrown away. The bologna that

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155723 05/17/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3001 GALAXY DR RIVER POINTE HEALTH CAMPUS **EVANSVILLE, IN47715** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE their buckets with the sanitizing solution. was in the resealable package and had the date that had been torn The first sink was observed to have soapy through was thrown away. The water in it with various cooking pans in it, vegetable soup that had no label was sticking up out of the water. The second also thrown away. The reddish pool sink was also filled with clear water as of liquid under the meat tray on the floor was cleaned and sanitized well as the third sink, also filled with appropriately. clear liquid. Dishwasher #1 explained how the sanitizer is dispensed by a hose The bag of frozen unlabeled fish was on the wall connected to a bottle of thrown out of the freezer. The speed sanitizer. Viewing the bottle of sanitizer racks in the refrigerator that were moved to get to the freezer had jello was obstructed as there were dish racks that spilled on the floor of the walk stacked up in front of it. Upon request, in refrigerator as they were moved. Dishwasher #1 was asked to test the It was immediately cleaned up. strength of the sanitizer level in the 3rd The bowl of shrimp that was undated sink. He took the test strips, labeled and unlabeled was thrown out. Phydration, and took the orange strip of Plastic wrap was ordered and paper and stuck it in the 3 compartment quantity and availability will be sink. He indicated he was to hold the maintained by the FSM/ Designee. strip in the water for 10 seconds. When Food on the speed racks will be he removed the test strip, it was the same covered with plastic wrap. Completion Date 6-10-2011 orange color as when he removed it from the dispenser. Dishwasher #1 indicated All dietary staff will be in-serviced they "were low on sanitizer." When the on proper food storage procedures of dispensing tube was followed along the food in the refrigerators as well as wall, behind the stacked dish racks, an the freezers. The dietary staff will also be in-serviced on proper empty metal holder was observed. He handling and usage of leftover foods. indicated someone had "gone to get more" Completion Date 6-10-2011 sanitizing solution. FSM/ designee will monitor the refrigerators and freezers daily x 6 On 5/12/11 at 3 P.M., a copy of the May months to ensure proper storage of 2011 "Dishwasher Temp (temperature log) food and leftovers is being done. was received from the Administrator. The results of this monitoring will be This form had dishwasher temperatures forwarded to the QA committee for documented for each of the 3 meals a day

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SU			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155723	A. BUI	LDING	00	05/17/2011
		155725	B. WIN			03/17/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
DIVED D	OINTE HEALTH CA	MDUS			ALAXY DR VILLE, IN47715	
					VILLE, IN477 13	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION DATE
1710		6 rinse temperatures		ino	further recommendations if nee	
		ocumented to be below			Completion Date 6-10-2011	uou.
	180 degrees Fahr				-	
	~	ged from 170 - 179			All unpasteurized were thrown	
	degrees Fahrenhe				Staff was in-serviced on the pol	icy of
	degrees ramemic	51t.			serving unpasteurized eggs. Completion Date 6-10-2011	
	0:: 5/16/11 -4 13	D.M. Alsa Danismal			Completion Date 0-10-2011	
		P.M., the Regional			FSM/Designee will continue to	
		RR] was interviewed. He			monitor food orders to ensure the	
		se temperature of the			availability of pasteurized eggs	to
		ld be at least 180 degrees			cook. Completion Date 6-10-2011	
		ndicated that kitchen			Completion Date 0-10-2011	
		een educated enough to			Thermometers have been placed	d in
	be aware of requi	ired temperatures."			all refrigerators and freezers pe	
					policy. All dietary staff includi	- 1
		tour of the kitchen, on			our regional representative have in-serviced on where the	e been
		M., Cook #2 entered the			thermometers are located as we	11 as
		tor. He lifted a single			safe temperature ranges for the	11 43
	~	yellow pudding like			freezer and refrigerators. Each	
		elf. This bowl was not			dietary staff member has been	
		2 was unable to identify			in-serviced on where to record	daily
		oowl. A roast type ham			temps and who to contact if temperatures are not within ran	70
		one of the shelves. Cook			The in-service included the disp	-
		date on the ham (which			of food that ever encounters out	l l
		e approximately 3			range temperatures.	
	*	te of 5/5/11. Cook #2			Completion Date 6-10-2011	
	indicated this har	n should have been			All food in the stand we for	N/OC
	thrown out on 5/8	8/11, as they keep			All food in the stand up freezer disposed of. A freezer log was	was
	potentially hazar	dous foods for only 3			placed on the outside of the star	nd up
	days. A package	of roast beef, identified			freezer.	·
	by Cook #2 to be	approximately 3-4			Maintenance was called to chec	· · ·
	pounds, was part	ially covered with plastic			temperature problem in the free	zer.
	wrap. Cook #2 is	ndicated this roast beef			The freezer was fixed. Completion Date 6-10-2011	
	was lacking a dat	te. A package of turkey			Completion Date 0-10-2011	
	meat (2 ounces)	was opened but not dated			All equipment has been pulled	out

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPI	ETED
		155723	B. WIN			05/17/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		1	ALAXY DR		
RIVER P	POINTE HEALTH CA	AMPUS		1	VILLE, IN47715		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	as to when it wa	s opened. An opened			and the floors have been cleaned	ed	
	package of bologna was also observed.				including the edges.		
	This was in a re	sealable package but was			Completion Date 6-10-2011		
	not dated as to when it was opened and				The hand washing sink has bee	nn.	
		on the package was unable			thoroughly cleaned and the tras		
	1	and been torn through. A			removed with a new one place		
		bserved in the walk in			the hand washing sink. All spa	-	
	_				on the walls have been wiped of		
	1	an uncut baked cake in it.			All shelves have been cleaned		
		ot covered or dated. A 15			well as a new microwave purch		
	quart container was observed with vegetable soup in it. This container was undated. Cook #1 indicated the soup had been made yesterday. A pool of a reddish				and the old stained one thrown	out.	
					Completion Date 6-10-2011		
					The staff have been in-serviced	lon	
					the proper way to keep trash	1 011	
	liquid type subs	tance was observed			contained and the trash overflo	wing	
	around the base	of a leg of one of the			in the trash can was taken out.		
	shelves in the w	alk in refrigerator. The			Completion Date 6-10-2011		
	diameter of the	pooled reddish liquid was			TTI		
	1	and was drying on the			The staff have been in-serviced		
		above the reddish pool,			how to properly wash the floor in the dish room. They have al		
	1 -	ef, placed directly on the			been in serviced on proper use		
	metal shelving.	er, placed directly on the			three compartment sink and cro		
	iniciai sherving.				contamination.		
	A 4 0 45 A 34 41	11 in Contract			Completion Date 6-10-2011		
		ne walk in freezer was					
	1	g of frozen, unbreaded			All staff will be in-serviced on		
		as observed. The fish			washing of the hand sink as we	ell as	
		nich Cook #2 identified as			the 3 compartment sink. Completion Date 6-10-2011		
	_	e, and observed that the			Completion Date 0-10-2011		
	_	led, but had a hole, at least			Cleaning schedules have been	posted	
	6 inches in diam	neter in the exposed side			and staff has been in serviced of		
	of the bag. The	bag was not labeled as to			their individual responsibilities	for	
	its contents.				kitchen sanitation.		
					Completion Date 6-10-2011		
	At 1:30 P.M C	ook #2 indicated he was			FSM/designee will monitor the		
	1	e of the fish fillets in the			cleaning schedules daily x 6 m		
	1 Some to dispose	or the fight fineto in the			the semination during A 0 III	J.16115	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155723	B. WIN			05/17/2	011
					ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF	PROVIDER OR SUPPLIEF	ę.		3001 G	ALAXY DR		
	OINTE HEALTH CA				VILLE, IN47715		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL				ГЕ	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		IAG		11	DATE
	1	n the opened bag. Cook			to ensure staff is performing ass duties. Audits will be forwarde		
		alk in refrigerator and			the QA committee for further re		
	1	g, wheeled rack with			and recommendation as needed		
	1 -	pans of red liquid in			Completion Date 6-10-2011		
	them. When Co	ok #2 moved the rack, the					
	wheel stuck and the pans of red liquid				Staff has been in serviced on the		
	spilled and spattered on the floor of the				of hair restraints in all kitchen f		
	walk in refrigera	tor.			prep areas. Hair restraints have placed outside the dining room		
					staff other than dietary that need		
	A covered bowl of cooked shrimp was				enter the kitchen may do so with		
	observed at 2 P.M. on the bottom shelf of				hair net in place.		
	the walk in refrigerator. This shrimp was				Completion Date 6-10-2011		
	1	oowl had water in it and					
		ced in a pan with ice in it.			Overall sanitation will be monit		
		of the shrimp was 30			by the FSM/Designee on a week basis through a sanitation score		
	_				checklist. Sanitation checks wi		
	~	1 indicated the pre			completed weekly for 6 weeks		
	1	ad been thawed in the			then months thereafter for 10 m		
	1 -	e package yesterday and			with the results being forwarded	d to	
	when they were	thawed, water was added.			the QA committee for further re		
					and recommendations as needed	d.	
		20 A.M., the reddish			Completion Date 6-10-2011		
	liquid observed	pooled at the base of the					
	shelf leg in the v	valk in refrigerator was					
	again observed.	The reddish puddle was					
	approximately 6	inches in diameter.					
	At 8:20 A.M. on	5/10/11, Cook #3 was					
	1	arding ham in the walk in					
	1	e indicated the chunk of					
	1 -	s pounds. The cut ham					
		-					
	was covered with plastic wrap but was not dated. She indicated the ham had been						
	1 -	y. She removed the ham					
	I from the retriger	rator and placed it in a					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP: 05/17/2	LETED	
	PROVIDER OR SUPPLIER		3001 G	ADDRESS, CITY, STATE, ZIP CO ALAXY DR VILLE, IN47715	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	plastic container	·				
	freezer. The ope type fish remaind Cook #3 threw the fish away. On 5/11/11 at 8:1 refrigerator was puddle remained	a #3 toured the walk in ened bag of frozen fillet ed in the walk in freezer. The opened bag of frozen at 30 A.M., the walk in observed. The reddish around the same leg of				
	shelving as observed on 5/9/11 and 5/10/11. On 5/11/11 at 11:45 A.M., the RR					
	provided a copy of the undated policy and procedure for "Food and supplies shall be properly stored to keep foods safe and preserve flavor, nutritive value and appearance." The procedure, included but was not limited to, the following: "Food is covered, dated and stored loosely to permit air circulationPrepared perishables such aspuddingsare stored in a refrigerator and covered, labeled and dated until usedleft overs are refrigerated immediately and used within 72 hours or frozenAll foods in the freezer are wrapped in moisture proof wrapping or placed in suitable containers to prevent freezer burn. Items are labeled					
	On 5/11/11 at 3:0	08 P.M., the kitchen was				

CROSS-REFERENCED TO THE APPROPRIATE	ed 1
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY CONTROL OF CORRECTION OF CORECTION OF CORRECTION OF CORRECTION OF CORRECTION OF CORRECTION OF	
toured with the RR At this time Cook	(X5) COMPLETION DATE
#2 was asked by the RR to cover the pans of carrot salad which were observed in the walk in refrigerator on standing racks uncovered. Cook #2 indicated they didn't have any plastic wrap. The carrot salad was then covered with cookie sheet type pans. On 5/12/11 at 11 A.M., the RR was interviewed. He indicated "we have really fallen short on giving them (staff) the tools they need to succeed." He indicated inservicing had begun on that date. On 5/12/11 at 11:30 A.M., the RR provided a copy of the policy and procedure for "Leftover foods will be utilized in an appropriate and safe manner to aid in controlling waste." This policy was undated. The procedure included, but was not limited to, the following: "Leftovers should be covered, dated, labeledas soon as meal service is finishedleftovers which are frozen are covered so they are air-tight and moisture proof. They are labeled with item and dateThe Dining Service Manager or cook checks for leftovers each morning and determines how to use them 3. During initial tour of the kitchen on 5/9/11 at 9:30 A.M., the walk in refrigerator was observed. Five boxes of	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE SUI COMPLET		
AND PLAN	OF CORRECTION	155723	A. BUII	DING	00	05/17/201	
		155725	B. WIN			03/17/201	1
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ALAXY DR		
RIVER P	OINTE HEALTH CA	MPUS			VILLE, IN47715		
(X4) ID		TATEMENT OF DEFICIENCIES	-	ID	, -	(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		OMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	18 count eggs we	ere observed. Cook #2					
	indicated these e	ggs had just been bought					
	from a local grocery, as they had run out						
	of eggs and the e	ggs were not pasteurized.					
	He indicated they	y were getting a food					
	order in on that d	lay.					
	On 5/11/11 at 8:4	40 A.M., Cook #1 was					
	observed in the k	itchen. A container					
	housing shelled e	eggs was observed on the					
	counter. No markings were observed on						
	these eggs. At this time, Cook #1 took						
	two of the shelled	d eggs from the counter,					
	cracked them and	d put them in a hot					
	skillet. He then p	out them on a plate with					
	additional breakf	ast food and started to					
	walk out of the k	itchen. At that time he					
	was interviewed.	He indicated the eggs					
	he just cooked w	ere not pasteurized and					
	were cooked with	h the whites to a medium.					
	He stated the yol	ks were not hard cooked.					
	Cook #1 indicate	ed that sometimes they					
		nd buy them. He					
		ight if the whites were					
		lium it was OK to serve					
	them. At this tin	ne Cook #3 was					
	interviewed. She	e indicated she thought					
	^ ~	gs had to be cooked hard.					
	Cook #1 then thr	ew the medium cooked					
	eggs out.						
		P.M., the RR provided a					
		y and procedure for "safe					
	and sanitary hand	dling of food will be					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MULTIPLE CO A. BUILDING B. WING	00	CON	fe survey MPLETED 7/2011		
	PROVIDER OR SUPPLIER		STREET A 3001 G.	ADDRESS, CITY, STATE, ZIP ALAXY DR VILLE, IN47715	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
Mo	employed during policy was undate but was not limit "only pasteurized	g food production." This ted. This policy included, ted to, the following: d raw eggs are served."	ino			DATE	
	interviewed. He should be pasteu were in a "situati	:A.M., the RR was indicated that all eggs rized. He indicated they ion where they ran to other (non pasteurized)					
	5/9/11 at 9:45 A. was observed. Cothe thermometer temperature. Co	tour of the kitchen on M., the walk in freezer Cook #2 was looking for to read the current ok #2 was unable to find a the walk in freezer.					
	Log" was observed walk in refrigeral had no date for the but was complete the month. The	efrigerator/Freezer Temp red on the outside of the tor/freezer door. This log he "Month"on the form ed through the ninth of temperature for each k in freezer was "-11."					
	observed. Cook thermometer to detemperature in the At this time, the	e milk cooler was #1 was unable to locate a check the current ne cooler. temperature to the stand ead by Cook #2 as 31					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			(X3) DATE SURVEY COMPLETED 05/17/2011	
		100720	B. WIN				1112011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CO ALAXY DR	DE	
RIVER P	OINTE HEALTH CA	MPUS		1	VILLE, IN47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAG		neit). There were 5 large,		IAG	BEITELENCT,		DATE
	· ·	f ice cream. One of the					
	-	paper lid, which was not					
		ream closed. Three					
	_	per lid round was					
		ne edge, thus exposing ice					
	_	niner had approximate 1/3					
		missing. The ice cream					
		be melting, with soft					
		observed from the inside					
	edge of the container, at least 1 inch in						
	toward the center of the container. Fluid						
	ice cream was ob	oserved in the center of					
	the ice cream. C	ook #2 threw this drum					
	of ice cream awa	y. All 5 drums of ice					
	cream were soft	enough to be able to be					
	pushed in when t	touched from the outside					
	of the container.	One of the other					
	1 -	ners of ice cream was					
	1 ^	same degree of melting					
		e, with mushy ice cream					
		1 inch in from the inside					
	_	niner. Cook #2 indicated					
		e" and thought maybe the					
		efrost mode. He notified					
		man of the freezer.					
		r the maintenance man,					
		mptying the stand up					
		oved the following: 4					
	_	of ice cream; a case of					
	I -	cup" food items, with					
		magic cups missing					
	l ` •	one of the lids of the					
	magic cup, the m	nelted substance emerged					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED					
AND PLAN	OF CORRECTION	155723	A. BUI	LDING	00	05/17/2	
		133723	B. WIN			03/11/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ALAXY DR		
RIVER P	OINTE HEALTH CA	MPUS		1	VILLE, IN47715		
					VILLE, 11477 13		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		f the lid); 3 pre packaged	1	1.10			5.112
		,, I I C					
	cream pies; 2 cases of 50 count, 4 ounce servings, of mighty shakes and one 75						
	• •	unce mighty shakes was					
		m the freezer. These					
		e to be pushed on the					
		Cook #2 indicated the					
		dn't be soft. A single					
		shake was removed from					
	the back of the freezer and was frozen solid when the carton was touched. At						
	10:05 A.M., the above items were moved						
		eezer on a cart. Also					
		e freezer were 3 boxes of					
		; one prepackaged					
	cheesecake, choc	-					
		nd 4 prepackage loaf					
	-	angel food cake was					
		one, one inch slice					
	_	gel food cake was not					
		red, was not dated and					
	was also observe	d to be soft.					
	On 5/0/11 of 11 /	A.M., a copy of the "Refrigerat	,				
		re) log was received from the					
	• • •	hich hung in the kitchen on the					
	_	er. This log was completed for					
	_						
		a was left blank. The categorie					
		e following: "walk in refrigera					
	•	refrigerator; milk cooler." Doo	1				
	_	nis form of an area to documen	'				
	freezer temperatu	ires.					
	On 5/0/11 -4 11:3	20 A.M. the tower and tower					
	$On \frac{5}{9}/11 \text{ at } 11:3$	30 A.M., the temperature					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4Q0D11

Facility ID:

002280

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155723	A. BUILDING	00	05/17/2011
		100720	B. WING	ADDRESS SITE STATE SID CODE	00/11/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE ALAXY DR	
	OINTE HEALTH CA		EVANS	VILLE, IN47715	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1710		checked on the second	ind		DATE
		l Care Unit dining room			
		tant #1. She indicated			
	'	astic jug of reduced fat			
		in a plastic tub of ice.			
		temperature of the milk			
		ug with a kitchen			
	"	read the temperature to			
		hrenheit. She then stated			
	"that shouldn't be	e" and threw the gallon of			
	milk away. She	indicated the milk had			
	not been "buried far enough in the ice."				
	On 5/9/11 at 1:32	2 P.M., the temperature of			
	the stand up free:	zer was observed to be 8			
	degrees F. The f	reezer was empty at the			
	time.				
	On 5/11/11 at 11:	:45 A.M. a copy of the			
	policy and proced	dure for "Food and			
		properly stored to keep			
	_	reserve flavor, nutritive			
	1 1 1	rance." This policy was			
	1	ocedure included, but			
	was not limited to				
		are placed in every			
	· -	so as to be easily visible			
		in the upper third part of			
	the front of the st				
	1 ^	ll be recorded on the			
	Refrigerator log				
	*	age temperatures will be			
	at 0 degrees F (F	<i>'</i>			
	below Iempera	tures will be recorded on			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MULTIPLE (A. BUILDING B. WING	00	(X3) DATE COMP 05/17/2	LETED	
	PROVIDER OR SUPPLIEF		3001	TADDRESS, CITY, STATE, ZIP C GALAXY DR ISVILLE, IN47715	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	!	perature log at least twice				
	in freezer temper all and/or any re	was lacking of the reach rature being monitored at efrigerator and/or freezer eratures monitored twice				
	On 5/11/11 at 2:50 P.M. a tour was conducted with the Facilities Regional Representative (Rep.) (RR). In the main dining room, located directly off the kitchen, the RR was unable to locate log, documenting the temperature was being monitored in this refrigerator.					
		e walk in freezer was RR. He was unable to ter.				
	At 3:13 P.M., the milk cooler was toured with the RR. He was unable to find a thermometer in the milk cooler.					
	indicated on the Dietary staff left P.M. She indica arrived the morn temperature in the degrees Fahrenh was informed the	P.M., the Administrator evening of 5/8/11, the the department about 10 ted when the dietary staffing of 5/9/11, the are reach in freezer was 60 eit. She indicated she at the door to the reach in losed properly the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE : COMPL	ETED	
		155723	B. WINC	·		05/17/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RIVER P	OINTE HEALTH CA	MPHS			ALAXY DR VILLE, IN47715		
					VILLE, IIN477 13		(1/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG			DATE
	evening of 5/8/11	I, the fan froze up to the	İ				
	reach in freezer, thus leading to the increased temperature.						
		tour of the kitchen, on					
		M., the following was					
	observed:						
	The flooring of 4	he kitchen was observed					
	to have scattered dust, debris and bits of food items, especially along the wall edges and around the legs of tables and appliances.						
	appnanees.						
	The only hand w	ash sink was observed					
	I	g: in the base of the sink					
	was a small brusl	h and a sponge with					
	seeds on it. The	basin of the sink was					
	observed to have	brownish areas of					
		throughout. The same					
		was observed along the					
	1 ^ ~	faucet fixture and along					
	ı ~	sink. The wall behind the					
		ed to have various					
		out up to chest level on					
		nd wash sink was located l, foot pedal operated					
		d to this trash can was					
		th various spatters of					
	<u> </u>	The trash can was					
		r. The walls on the back					
	_	ash can were also laden					
		dried substances, from					
	chest height on the						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPL		
ANDILAN	OF CORRECTION	155723	A. BUI			05/17/2	
		100.20	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ALAXY DR		
RIVER P	OINTE HEALTH CA	MPUS		1	VILLE, IN47715		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORR			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
IAU	The open shelf up cooking area was had at least 2 but on it. Throughout dark black brown. The microwave we dried spatters of a outside of the over based of the microwave a very dark, substance. This is front half of the oback from the ed. Dried splatters we throughout the m substance was about the large wheele observed, at 1:10 and the dishwash overflowing and On 5/10/11 at 8:2 sink was observed remained in the standard the control of th	nderneath the sink in the sobserved. This shelf exets of sanitizer solution at the shelf were areas of a sticky residue. was observed to have a light substance on the en. When opened, the rowave was observed to a blackish colored substance covered the oven bottom, extending ge at least 2 inches. Here also observed hicrowave. This black ble to be scraped off. ed trash can was of P.M. in the cooking area aring area, to be without a lid. 20 A.M., the hand wash and again. The small brush sink basin as observed on dition of the sink, walls		IAU			DATE
		n can also remained the					
	same as observed	d on 5/9/11.					
		20 A.M., the floor					
	condition, shelf c						
	microwave remai	ined the same as	L				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723	(X2) MULTIPLE CC A. BUILDING B. WING	00	li i	E SURVEY PLETED 2011
NAME OF PROVIDER OR SUPPLIER RIVER POINTE HEALTH CAMPUS			3001 G	ADDRESS, CITY, STATE, ZIP (ALAXY DR VILLE, IN47715	CODE	
(X4) ID PREFIX	SUMMARY S	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION
TAG	observed on 5/9/	. LSC IDENTIFYING INFORMATION) 111.	TAG	DEFICIENCY)		DATE
	again observed.	A.M., the microwave was The dried spatters to the dark substance to the as observed on 5/9/11 on				
	sink was again or remained in the initially on 5/9/1 sink, walls and c	10 A.M., the hand wash bserved. The small brush sink basin as observed 1. The condition of the overed trash can also me as observed on 5/9/11.				
	under the sink in	10 A.M., the open shelf the food prep area ne as observed on 5/9/11				
	was observed in Dishwasher #2 p from the floor ardish work space was laying flat a water nozzle with and began scrub. This is the same observed to clear being run throughthen rolled the replaced it in the s	the dish room. bicked up a rubber mat and placed it on the dirty. The rubber floor mat and he then took the dish he a brush on the end of it bing the rubber floor mat. dish water nozzle anse dirty dishes prior to the dishwasher. He abber floor mat up and econd compartment of the ent sink, where there was				

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP: 05/17/2	LETED
	PROVIDER OR SUPPLIEF		3001 G	address, city, state, zip codi BALAXY DR SVILLE, IN47715	.	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	He then began so	ober floor mat rolled up. crubbing the dish area with a brush/broom.				
	began running w compartment of The rubber mats floor. Dishwash He indicated the shift and it was of breakfast. He in	ater into the second the 3 compartment sinks. had been replaced to the er #1 was interviewed. y clean the sink twice a cleaned right after dicated he had not mpartment since after				
		n 5/11/11, a pan was g in the 2nd compartment ment sink.				
	At 12:15 P.M., Dishwasher #1 was interviewed. He indicated they were out of sanitizer solution. He indicated they had some for breakfast but were out at that time.					
	·	ne RR returned with and indicated, "this will the now."				
	interviewed. He	ishwasher #2 was indicated he had not as 3 compartment sinks				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMP 05/17/2	LETED
NAME OF PROVIDER OR SUPPLIER RIVER POINTE HEALTH CAMPUS			3001 (ADDRESS, CITY, STATE, ZIP CO GALAXY DR SVILLE, IN47715	ODE	
(X4) ID PREFIX	SUMMARY S	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETION
TAG	On 5/11/11 at 4: interviewed. The and the AFSM n	55 P.M., the RR was e RR indicated the FSM nonitored kitchen e monitored them.	TAG	DEFICIENCE		DATE
	toured with the I sink remained as 5/10/11 and 5/11 the brush, lying	45 A.M., the kitchen was RR. The condition of the sobserved on 5/9/11, /11. The RR indicated in the base of the sink, ed to clean employees'				
	interviewed. He to locate any con cleaning schedul indicated the las	:30 A.M., the RR was indicated he was unable indicated documented les for the kitchen. He tompleted cleaning ne before the FSM left.				
	"The handwashi and sanitized on to defined proce This policy was received from the review. Documents	:45 A.M., the Policy for ng sink will be cleaned a routine basis according dures" was reviewed. dated 2009 and was e RR at the time of entation was lacking as to of "routine basis" ency of cleaning.				
	the daily, weekly schedules were i	2:20 P.M., blank copies of y and monthly cleaning received. Daily Tasks are not limited to, the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE : COMPL		
		155723	A. BUI B. WIN	LDING IG		05/17/2	011
NAME OF	PROVIDER OR SUPPLIER	∥			DDRESS, CITY, STATE, ZIP CODE	!	
RIVER E	POINTE HEALTH CA	MPHS			ALAXY DR VILLE, IN47715		
		STATEMENT OF DEFICIENCIES		L	VILLE, 111477 15		(V.5)
(X4) ID PREFIX		ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	following: "3 w	ell sink, each use; hand					
	sink; juice mach	ine each meal;					
	microwave; floo	rs sweep/mop; work table					
	cooks area; work	tables serving area."					
	6 On initial tou	r of the kitchen, on 5/9/11					
	1	e kitchen was observed in					
	1	anner: The one main					
	1	kitchen was from the					
	1 -	m. The one main walk					
	1	ont of the kitchen to the					
	back, went direc	tly by the food prep table					
	area. The food p	orep/cook area was					
		in the kitchen off to the					
	left of the main	walk way. Staff were					
	1	time, to walk into the					
		hair restraint on and					
	1 ~	ets" (with residents' food					
		on the side of the ice					
		te machine was also					
		walkway from the shorter					
	side of the food	prep table.					
	On 5/9/11 at 10:	15 A.M., the					
		as observed walking into					
	the kitchen with	out a hair restraint in					
	place. At the tin	ne she walked by the food					
	prep table, unco	vered chicken breasts					
	were on the cour	nter being prepared.					
	On 5/9/11 of 12	P.M., Physical Therapy					
	1	erved inside the kitchen					
		air restraint on. Meal					
		in progress at the time.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723			Ì	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE : COMPL	
			B. WIN			05/17/2	011
	PROVIDER OR SUPPLIER			3001 G	ALAXY DR VILLE, IN47715		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDENCE DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
	service director) without hair restraint on. food prep area without hair restraint on. food proces.	20 A.M., LPN #1 entered out a hair restraint on. He is ticket, entered the is to the ice machine and stuck the order of the ice. A.M., the Maintenance impanied by an outside ralked through the main en. The service worker hair restraint on. The pervisor was observed					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/17/2011
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP CODE	
RIVER P	OINTE HEALTH CA	AMPUS		SALAXY DR SVILLE, IN47715	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
	was received fro included, but wa following: "The requirements reg will wear hairned covers the hair was serving food." The Administration sheet, on 5/9/11	m the RR. The policy s not limited to, the organization has strict garding hair: Employees is that COMPLETELY while in the kitchen or or provided a Census at 11:00 a.m., indicating ded on the skilled units in			

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/17/2011
	PROVIDER OR SUPPLIER		3001 0	ADDRESS, CITY, STATE, ZIP CODE GALAXY DR SVILLE, IN47715	•
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LIGGUIDENTIFY DISCONMATTIONS	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
F0441 SS=D	The facility must el Infection Control F a safe, sanitary ar and to help prever transmission of distribution o	stablish an Infection Control nich it - ontrols, and prevents cility; orocedures, such as e applied to an individual cord of incidents and related to infections. read of Infection ction Control Program resident needs isolation to d of infection, the facility esident. st prohibit employees with a ease or infected skin contact with residents or contact will transmit the st require staff to wash their direct resident contact for ng is indicated by accepted	TAG	DEFICIENCY)	DATE
		andle, store, process and as to prevent the spread of			
	record review the a nurse washed h her gloves, durin	ervation, interview, and e facility failed to ensure her hands after removing g dressing changes, for 1 dent observed during a	F0441	F 441 Res #36, 38, and 23 suffered n effects from the findings on the 2567. Completion Date 6-10-2011	I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPL	COMPLETED	
		155723	B. WING 05/17/2011				011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	· ·		3001 G	ALAXY DR		
	OINTE HEALTH CA			L	VILLE, IN47715		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	-	TAG	DLI ICILIACI)		DATE
	1 .	, in the sample of 13, and					
	1 **	mental sample resident			All residents have the potential	to be	
		a dressing change, in the			affected by the alleged deficient		
		mple of 9. (Residents			practice and through alterations		
	#38, #36)				processes and in servicing will		
					ensure correct actions to preven	ıt	
	B. Based on rec	ord review and interview,			spread infection are followed.		
	the facility failed	d to ensure 1 of 13			Completion date 6-10-2011		
	sampled resident	ts had a tuberculosis skin			Nursing staff will be in serviced	l on	
	test given upon a	admission. (Resident			proper hand washing procedure		
	#23)			glove usage, and proper precaution			
	'			techniques to prevent spreading of			
	Findings include	·			infection		
	i manigs merade	··			Systemic change will be that nu	-	
	A 1 During initio	al tour on 05/09/11 at			staff will have return demonstra	ition	
	~		of skills to prevent infection including hand washing and glove				
	•	dent #38 was identified by	application. Skills will be re-evaluated on an annual basis for				
		ctor of Health Services] as					
		d having a wound vac			competency.		
		ght outer calf for a stasis			Nursing staff have been in servi	iced	
	ulcer.				on TB skin test policy and		
					procedures. Systemic change A		
	The clinical reco	ord of Resident #38 was			has been trained as a TB instruction Date 6-10-2011	ctor.	
	reviewed on 05/	11/11 at 4:30 P.M.			Completion Date 0-10-2011		
	The ADoHS [As	ssistant Director of Health			DHS/Designee will monitor 3		
	Services] was ob	oserved, on 05/10/11 at		random residents for resident of			
	_	ange the wound vac			that includes hand washing, glo		
		dent #38's right outer calf.			usage, and care provided to ens		
	_	s observed to perform			preventive infection control pra followed5x week x one montl		
		on gloves, and gather the			a week x one month then we		
	1	es to change the wound			with results forwarded to QA	-	
		e ADoHS was observed			committee monthly x 6 mont		
					and quarterly thereafter for	.110	
		gloves and don clean			review and further		
gloves without performing handwashing				To view and rutulet			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPI		
		155723	A. BUI B. WIN	LDING		05/17/2	
					DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		1	ALAXY DR		
	OINTE HEALTH CA			EVANS	VILLE, IN47715		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG		crobial gel. The ADoHS		IAG	suggestions/comments		DAIL
		remove the old dressing,			suggestions/comments		
		don clean gloves without					
		Iwashing or using					
		els. The ADoHS was then					
		n the peri-wound, doff			DHS/designee will review a		
		clean gloves without			new admissions in am clinic		
		dwashing or using			meeting to assure TB skin to		
		el. The ADoHS then			was administered per policy week x one month 3x a wee		
	_	und, doffed gloves, and			one month then weekly with		
		oves without performing			results forwarded to QA	•	
	_	using anti-microbial gel.			committee monthly x 6 mon	iths	
	ı	s then observed to apply			and quarterly thereafter for		
		ressing to the wound bed,			review and further		
		don clean gloves without			suggestions/comments		
	_	lwashing or using			Completion Date 4-2-2010		
	anti-microbial g	el. The ADoHS was then					
	observed to app	ly the secondary dressing					
	over the wound,	doff gloves, and don					
	clean gloves wit	hout performing					
		using anti-microbial gel.					
	1	s then observed to doff					
	gloves and perfo	orm handwashing.					
		e, completed by the Nurse					
		dated 05/10/11, indicated,					
		ver extremity] calf					
		nd of wound dark colored					
		rdened faint foul odor					
	· ·	The Progress Note further					
		nged frequency of 3X wk					
	[three times a w	еекј.					
	A Policy and Pro	ocedure, provided by the					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723	A. BUILDING	00	(X3) DATE SURVEY COMPLETED 05/17/2011
	PROVIDER OR SUPPLIER		3001	T ADDRESS, CITY, STATE, ZIP C GALAXY DR ISVILLE, IN47715	
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION)	SHOULD BE COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE DATE
	ADoHS on 05/11	1/11 at 2:30 P.M.,			
	indicated, "Hand	washing is the single			
	most important f	actor in preventing			
	transmission of i	nfection. Inadequate			
	handwashing has	been responsible for			
		of infectious disease in			
		m Care Facility] 3.			
		kers shall wash hands at			
		d. After removing gloves,			
		ct with excretions or			
	secretions,resi	dent equipment"			
	In an interview w	vith the ADoHS, on			
	05/11/11 at 2:30	P.M., she indicated, "You			
	wash your hands	before and after a			
	treatment and if	you change gloves you			
	should wash you	r hands."			
	A2. On 5/9/11 a	t 3:25 p.m., the Assistant			
	Director of Healt	th Services [ADoHS] was			
	observed doing a	treatment to Resident			
	#36's lower legs.	She washed her hands			
	and donned glove	es, removed the soiled			
	dressings from th	ne right leg, changed			
	gloves, cleansed	the areas, changed			
	gloves, applied c	lean dressings to the			
		changed gloves, removed			
	the soiled dressir	ngs from the left lower			
		ves, cleansed the areas,			
		applied clean dressings,			
	removed gloves	and then washed her			
		s no handwashing			
	between glove ch	nanges.			
	B1. During initia	al tour, on 05/09/11 at			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ		INSTRUCTION 00	(X3) DATE S COMPL		
		155723	A. BUI B. WIN	LDING IG		05/17/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
				1	ALAXY DR		
	OINTE HEALTH CA			EVANS	VILLE, IN47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		ident #23 was identified					5.112
	*	s interviewable and a new					
	_	he hospital. Resident					
		d at that time sitting in a					
	chair in her room	i.					
	The clinical reco	rd was reviewed, on					
		A.M., and indicated					
		s admitted to the facility					
	on 04/06/11.						
		D 11/1					
	The Immunization	•					
		ed Resident #23 received					
	a Tuberculosis te	st on 04/0 // 11.					
	The TB Screenin	g: Residents policy and					
		ded by the DoHS on					
	• • •	A.M., indicated, "Policy					
	All resident [sic]	either prior to or upon					
	admission,will	receive a 2-Step					
	Mantoux test for	tuberculosisMantoux					
	Test: Residents	, Admission, Two-Step,					
	Administer on or	before day of					
	admission"						
	To so the	A. A. D. HO					
		vith the DoHS, on					
	[Resident #23] d	P.M., she indicated, "She					
		until 04/07/11. We					
	should have done						
	Should have dolle	one on udmit.					
	3.1-18(e)						
	3.1-18(1)						
	. ,						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155723 05/17/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3001 GALAXY DR RIVER POINTE HEALTH CAMPUS **EVANSVILLE, IN47715** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must train all employees in F0518 emergency procedures when they begin to SS=E work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. F 518 F0518 06/10/2011 Based on observation, record review and interview, the facility failed to ensure No residents suffered any ill laundry supervisory staff and/or laundry effects from the deficient practice. staff were trained on department emergency procedures, for 1 of 1 laundry All residents have the potential to be affected by the deficient practice Supervisor, and for 2 of 2 laundry staff and through the in-servicing of all interviewed regarding emergency laundry staff, fire policies and procedures. This deficient practice had procedures will be learned and the potential to affect 52 residents residing practiced through regular drills. on the skilled units in the facility. Completion Date 6-10-2011 (Laundry Supervisor, Laundry Staff #1, All laundry staff will be in-serviced Laundry Staff #2) and trained on fire safety in the laundry area. Each laundry staff Findings include: member will be required to demonstrate the use of a fire extinguisher and verbalize the On 5/12/11 at 2:30 P.M., a tour of the placement of the fire pull in the Laundry was conducted with the laundry area and the building's gas Supervisor. She indicated the 2 large, shut-off valve. industrial size dryers, were gas dryers. Completion Date 6-10-2011 Regarding the location of the gas shut off Drills will be performed that include valve, the Laundry Supervisor indicated, scenarios where the gas shut-off she "didn't know the answer" and they had valve will need to be accessed and recently installed a door giving access to turned off. the area behind the dryers. She indicated Completion Date 6-10-2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4Q0D11

Facility ID:

002280

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155723 05/17/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3001 GALAXY DR RIVER POINTE HEALTH CAMPUS **EVANSVILLE, IN47715** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE she "wanted to say it's (gas shut off valve) A key to the door that leads to the there but I don't know." She indicated, for back of the dryer will be placed on a an emergency, staff are to pull the breaker hook outside the dryer enclosure. for the washers, located behind the Laundry staff will be trained on when washers. She indicated for emergency they would need to access the gas shut-off behind the dryers versus the procedures for the dryers, "we probably main building's gas shut-off. do (have shut off valves) for the dryers Completion Date 6-10-2011 but I don't have the answer for that. I've been here 7 years, not needed that before." ED/ Designee will randomly ask 20 employees a week on various shifts for 4 weeks to demonstrate where to At 2:40 P.M., the Laundry Supervisor was shut off gas to the building in case of asked to open the door (the one she a fire. ED/ designee will then indicated she thought provided access to randomly ask 10 employees a week the emergency shut off valve to the dryer) on various shifts for 4 weeks to in the laundry. The door was locked. She demonstrate where to shut off gas to the building in case of a fire. Results took out her key chain and tried to unlock will be forwarded to the QA the door. She indicated she did not have committee monthly x 2 months for the key to unlock the door. She indicated review and further suggestions. she would page the maintenance man to Completion Date 6-10-2011 come and unlock the door. At 2:41 P.M., she got on the phone and asked another staff member to page (maintenance Supervisor name). At this time, she indicated she was not sure of the location of the emergency fire pull for the department. She indicated she "had never been asked that before." She indicated she supervised 10 staff members. At 2:47 P.M., she got on the phone again and had the maintenance man paged again by a staff member. She indicated from that phone, they did not have the capability to page the maintenance

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	NSTRUCTION 00	(X3) DATE : COMPL	ETED	
		155723	B. WIN			05/17/2	011
NAME OF	PROVIDER OR SUPPLIEF	- {			ADDRESS, CITY, STATE, ZIP CODE		
DIVED E	OINTE HEALTH CA	\MDI IS		1	ALAXY DR VILLE, IN47715		
				<u> </u>	VILLE, IN477 15		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
-	•	tly overhead, but needed		-			
	1 ^	epartment to page the					
		pervisor. She indicated					
	1 -	e maintenance office but					
	if no one was the	ere, she would have to					
	1	artment and have them					
	_	nance Supervisor for her.					
		_					
	At 2:50 P.M., the	e Maintenance Supervisor					
	arrived to the de	partment. He indicated					
	the 2 dryers were	e gas dryers. He stated					
	that he and the a	ssistant maintenance man					
	were the only on	es with keys to the door					
	with access to th	e emergency gas shut off					
	valve. He indica	ated the door enclosing					
	the gas shut off v	valve had been in place					
	for 1 year.						
	0.5/10/11 4	15 D.M. d					
	On 5/12/11 at 4:						
		as interviewed. She					
		intenance Supervisor told					
	1	he emergency shut off					
	valve was during	z orientation.					
	On 5/12/11 at 4::	30 P.M., the					
		rovided a copy of a form					
	titled "Environm						
		is was the information the					
	maintenance ma	n provided to new					
		g orientation. The "tour"					
	1	s not limited to, the					
	1	ctrical and Gas shut offs".					
	The Administrator indicated at that time,						
	the main shut of	f valve to the gas dryers					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155723		A. BUI	LDING	onstruction 00	(X3) DATE COMPL 05/17/2	ETED	
		133723	B. WIN			03/11/2	011
NAME OF	PROVIDER OR SUPPLIES	3		1	ALAXY DD		
RIVER I	POINTE HEALTH CA	AMPUS			ALAXY DR VILLE, IN47715		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	was outside by the						
	1 '	ould turn the gas off by					
		ss. The Administrator					
		t that time, a key had been					
	1 ^	ndry room to give staff					
		ked gas shut off valve					
	located in the lat	undry department.					
	On 5/16/11 at 8:	30 A.M., the					
	Administrator w	as interviewed. She					
	indicated Laund	ry Staff #1 was the most					
		aff in the Laundry					
	department.	-					
	On 5/16/11 at 8:	30 A.M., Laundry Staff					
		ved. She indicated she					
		o the department in 2004.					
		the event of a fire, she					
	· ·	ey, which is now hanging					
		gain access to the gas shut					
	1 *	behind the dryers). She					
		off the gas shut off valve					
		s, she would pull up on					
	1	d behind the door/dryers.					
	1	2 indicated this was the					
	1 -	as aware of to turn off the					
	1 * *	e, behind the dryers. She					
	1 -	e was a fire in her					
		would go up to the front					
	1 -	o let them know of a fire.					
	1	to find a fire pull alert					
		-					
	station in the laundry department. She indicated there was one fire extinguisher						
		at. She indicated she was					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND FLAIN	OF CORRECTION	155723		LDING	00	05/17/2	
		100720	B. WIN		DDDEGG CITY GTATE ZID CODE	00/11/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ALAXY DR		
RIVER P	OINTE HEALTH CA	MPUS		1	VILLE, IN47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	ears ago on how to use					
		her. Laundry Staff #2					
		they do the training, I'm					
		the day." She indicated					
	she leaves for the	e day at 1 - 1:30 P.M.					
	On 5/16/11 at 8·4	45 A.M., the Maintenance					
		nterviewed. He indicated					
		e in the laundry, he					
		ted the staff to come to					
	1	t off valve, located out					
	_	om the laundry and					
		r of the building. He					
		as no written policy and					
		re specific to the laundry					
	_	indicated the shut off					
	valve turned gas						
		lve was labeled, "gas					
	~	The Maintenance					
		ated that if there was a					
	_	washer area/clean part of					
		rtment, he would expect					
		_					
		· ·					
	1 -						
	procedures for an	ı stari.					
	On 5/16/11 at 8:	50 A.M., the					
	_						
	1 **						
		_					
		_					
		-					
	shut off valve. He were done yearly procedures for all On 5/16/11 at 8: Maintenance Supply of the mate staff annual insertindicated the annual around the middle	50 A.M., the pervisor (MS) provided a rial he reviewed at the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723			A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/17/2011
NAME OF P	ROVIDER OR SUPPLIER		B. WING STREE	T ADDRESS, CITY, STATE, ZIP CODE	
	OINTE HEALTH CA			GALAXY DR ISVILLE, IN47715	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	1	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	information he sl inservicing. This limited to, the for Pre/Post test; Fire	vided a copy of the nared at the annual staff included, but was not llowing: "Fire Safety e safety - When the fire d Fire Safety - Fire Drill			
	Census sheet, on	or provided a copy of a 5/9/11 at 11:00 a.m., idents resided on the e facility.			
	3.1-51(b)				
R0000					
	_	esidential Findings were ce with 410 IAC 16.2-5.	R0000	The submission of this plan of correction does not indicate a admission by RIver Pointe H Campus that the findings and allegations contined herein a accurate and true represents of the quality of care and ser provided to the residents of F Pointe Health Campus. This facility recognizes it's obligat provide legally and medically necessary care and servies t residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the	an ealth d re an ation vices River ion to o it's

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4Q0D11 Facility ID:

002280

If continuation sheet

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PRINTED: 06/10/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723 NAME OF PROVIDER OR SUPPLIER			(X2) MU A. BUILI B. WING	DING STREET A	DDRESS, CITY, STATE, ZIP CODE	(X3) DATE S COMPL 05/17/2	LETED
RIVER POINTE HEALTH CAMPUS			3001 GALAXY DR EVANSVILLE, IN47715				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL	F	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
					requirements of participation comprehensive health care facilities. (for Title 18/19 programs) To this end, this pl correction shall serve as the credible allegation of complia with all state and federal requirements govrning the management of this facility. thus submitted as a matter o statute only.	lan of ance	

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Event ID:

4Q0D11

Facility ID: 002280

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723		(X2) MULT A. BUILDIN B. WING		OO	(X3) DATE S COMPL 05/17/20	ETED	
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
RIVER P	OINTE HEALTH CA	MPUS			LAXY DR ILLE, IN47715		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	I	D	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		EFIX			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE
R0119	employee shall be facility by the super designee) of the designee) of the demployees shall in (1) Instructions on specialized popular (A) aged; (B) developmentar (C) mentally ill; (D) dementia; or (E) children; served in the facility (2) A review of the applicable procedures (A) organization of (B) personnel polity (C) appearance are employees; and (D) residents' righty (3) Instruction in fi procedures, and fi preparedness, incorpocedures. (4) Review of ethic confidentiality in received to, and instruction each resident to we providing care. (6) Documentation	ty. facility's policy manual and ures, including: nart; cies; nd grooming policies for ss. rest aid, emergency re and disaster					
	supervising the or Based on observa	entation. ation, record review and	R011	9	R 119		06/10/2011
	· ·	cility failed to ensure			No residents suffered any ill		
	laundry Supervis	ory staff and/or laundry l on department			effects from the deficient practic	ce.	
	emergency proce	dures, for 1 of 1 laundry For 2 of 2 laundry staff			All residents have the potential be affected by the deficient pracand through the in-servicing of	tice	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
NAME OF	PROVIDER OR SUPPLIER	<u>"</u>	-	1	DDRESS, CITY, STATE, ZIP CODE		
RIVER F	OINTE HEALTH CA	AMPUS		1	ALAXY DR VILLE, IN47715		
(X4) ID		STATEMENT OF DEFICIENCIES		ID I			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	DATE
		rding emergency			laundry staff, fire policies and		
	procedures. This	s had the potential to			procedures will be learned and practiced through regular drills		
	affect 40 residen	ts on the Assisted Living			Completion Date 6-10-2011	•	
	Units [Residentia	al level of care].			Completion Date o 10 2011		
	(Laundry Superv	visor, Laundry Staff #1,			All laundry staff will be in-ser	viced	
	Laundry Staff #2	2)			and trained on fire safety in the		
					laundry area. Each laundry sta	ff	
	Findings include	y:			member will be required to demonstrate the use of a fire		
					extinguisher and verbalize the		
	On 5/12/11 at 2:	30 P.M., a tour of the			placement of the fire pull in the	e	
	Laundry was cor	nducted with the			laundry area and the building's	gas	
	supervisor. She	indicated the 2 large,			shut-off valve.		
	1 ^	yers, were gas dryers.			Completion Date 6-10-2011		
		cation of the gas shut off			Drills will be performed that in	clude	
		ry Supervisor indicated,			scenarios where the gas shut-o		
		the answer" and they had			valve will need to be accessed		
		d a door giving access to			turned off.		
	1 -	he dryers. She indicated			Completion Date 6-10-2011		
		ay it's (gas shut off valve)			A key to the door that leads to	the	
		know." She indicated, for			back of the dryer will be place		
		taff are to pull the breaker			hook outside the dryer enclosu	re.	
	1 -	located behind the			Laundry staff will be trained or		
		dicated for emergency			they would need to access the	_	
		ne dryers, "we probably			shut-off behind the dryers vers main building's gas shut-off.	us the	
	1 ^	f valves) for the dryers			Completion Date 6-10-2011		
	`	the answer for that. I've			•		
		s, not needed that before."			ED/ Designee will randomly a		
		-,			employees a week on various s		
	At 2:40 P M the	e Laundry Supervisor was			shut off gas to the building in c		
		e door (the one she			a fire. ED/ designee will then		
		ought provided access to			randomly ask 10 employees a	week	
		hut off valve to the dryer)			on various shifts for 4 weeks to		
	1	The door was locked. She			demonstrate where to shut off	-	
	1				the building in case of a fire. I	cesults	
	took out her key	chain and tried to unlock			will be forwarded to the QA		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MULTIP A. BUILDING B. WING		00	(X3) DATE: COMPL 05/17/2	ETED	
	PROVIDER OR SUPPLIER		30	01 GA	DDRESS, CITY, STATE, ZIP CODE LAXY DR (ILLE, IN47715	•	
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	(X5) COMPLETION
TAG	the door. She in the key to unlock she would page to	TA	j	committee monthly x 2 months review and further suggestions Completion Date 6-10-2011		DATE	
	come and unlock she got on the ph staff member to Supervisor name	the door. At 2:41 P.M., none and asked another page (maintenance e). At this time, she is not sure of the location					
	department. She been asked that the she supervised 1	e indicated she "had never before." She indicated 0 staff members.					
	At 2:47 P.M., she got on the phone again and had the maintenance Supervisor paged again by a staff member. She indicated from that phone, they did not have the capability to page the maintenance Supervisor directly overhead, but needed to call another department to page the maintenance man. She indicated she could call the maintenance office but if no one was there, she would have to call another department and have them page the maintenance Supervisor for her.						
	arrived to the dep the 2 dryers were that he and the a- were the only on with access to th	e Maintenance Supervisor partment. He indicated e gas dryers. He stated essistant maintenance man es with keys to the door e emergency gas shut off ated the door enclosing					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155723	A. BUII	LDING	00	COMPL 05/17/2	
		100725	B. WIN			03/17/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RIVER P	OINTE HEALTH CA	MPHS		1	ALAXY DR VILLE, IN47715		
					VILLE, IIV+77 10		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		valve had been in place					
	for 1 year.	with item country process					
	On 5/12/11 at 4:1	15 P.M., the					
		as interviewed. She					
		intenance Supervisor told					
		ne emergency shut off					
	valve was during						
	[
	On 5/12/11 at 4:3	30 P.M., the					
	Administrator pro	ovided a copy of a form					
	titled "Environme	ental Tour."					
	She indicated this	s was the information the					
	maintenance Sup	pervisor provided to new					
	_	g orientation. The "tour"					
		s not limited to, the					
	following: "Elec	etrical and Gas shut offs".					
	ı	or indicated at that time,					
	the main shut off	valve to the gas dryers					
	was outside by th	ne generator. In the event					
	of a fire, staff wo	ould turn the gas off by					
		s. The Administrator					
	also indicated, at	that time, a key had been					
		ndry room to give staff					
	1 ^	ked gas shut off valve					
		indry department.					
	On 5/16/11 at 8:3	30 A.M., the					
	Administrator wa	as interviewed. She					
	indicated Laundr	y Staff #1 was the most					
	recently hired sta	iff in the Laundry					
	department.						
	On 5/16/11 at 8:3	30 A.M., Laundry Staff					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MULTIPLE CC A. BUILDING B. WING	00	ľ	E SURVEY PLETED 2011	
	PROVIDER OR SUPPLIER		3001 G	ADDRESS, CITY, STATE, ZIP CO ALAXY DR VILLE, IN47715	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	had been hired to She indicated, in would take the k by the door (to g off valve located indicated to turn behind the dryers the knob, located Laundry Staff #2 only place she w gas shut off valve indicated if there department, she of the building to She was unable t station in the laurindicated there w in the department trained several yethe fire extinguis indicated "when already gone for she leaves for the On 5/16/11 at 8:4 Supervisor was i if there was a fire instructed/expect the main gas shut the back door from a round the corne indicated there we was a fire around the corne indicated there we was a fire around the corne indicated there we	the department in 2004. The event of a fire, she ey, which is now hanging ain access to the gas shut behind the dryers). She off the gas shut off valve is, she would pull up on the behind the door/dryers. Indicated this was the as aware of to turn off the ey, behind the dryers. She is was a fire in her would go up to the front of let them know of a fire. The offind a fire pull alert indry department. She was one fire extinguisher it. She indicated she was ears ago on how to use her. Laundry Staff #2 they do the training, I'm the day." She indicated is day at 1 - 1:30 P.M. 45 A.M., the Maintenance interviewed. He indicated in the laundry, he is the staff to come to the off valve, located out off the building. He was no written policy and the specific to the laundry				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155723	B. WIN			05/17/2	011
NAME OF F	PROVIDER OR SUPPLIER		·	1	ADDRESS, CITY, STATE, ZIP CODE ALAXY DR		
RIVER P	OINTE HEALTH CA	MPUS		EVANS'	VILLE, IN47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		indicated the shut off	+				5.112
	valve turned gas						
	_	lve was labeled, "gas					
		The Maintenance					
	•	ated that if there was a					
		washer area/clean part of					
		rtment, he would expect					
		side and turn off the gas					
		le indicated inservices					
	procedures for al	regarding fire policy and					
	procedures for an	i stair.					
	On 5/16/11 at 8:	50 A.M., the					
		pervisor (MS) provided a					
	copy of the mate	rial he reviewed at the					
	staff annual inser	vicing. The MS					
	indicated the ann	ual inservicing was done					
		e of the year and was					
	-	l employees. At that					
	, ,	vided a copy of the					
		nared at the annual staff					
	_	s included, but was not llowing: "Fire Safety					
	,	e safety - When the fire					
	· ·	d Fire Safety - Fire Drill					
	Procedures."						
	The Administrate	or provided a Census					
	sheet, on 5/9/11 a	at 11:00 a.m., indicating					
		sidents on Assisted Living					
	Units.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155723 05/17/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3001 GALAXY DR RIVER POINTE HEALTH CAMPUS **EVANSVILLE, IN47715** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE R0191 (o) Each facility shall have an adequate kitchen that complies with 410 IAC 7-24. R 191 R0191 06/10/2011 Based on observation, interview and record review, the facility failed to ensure No residents suffered any ill sanitation solution was at adequate levels; effects from the deficient practice. kitchen dishwasher temperatures were consistently maintained at adequate All residents have the potential to be affected by the deficient practice levels; foods were stored covered, dated and through the in-servicing of staff and labeled and/or disposed of according and alterations of processes will to facility procedure; serve pasteurized ensure eggs when not thoroughly cooked; proper sanitation and food storage monitor refrigerator/freezer temperatures; guidelines are being met. **Completion Date 6-10-2011** maintain the kitchen in a sanitary manner; and/or ensure all staff (including All dietary staff have been non-dietary staff) were wearing hair in-serviced on the proper way to restraints when in the kitchen, for 2 of 2 check sanitizer levels in their food preparation/serving areas and/or cleaning buckets as well as the 3 compartment sink. dining areas. (Main Dining Room, Main Completion Date 6-10-2011 Kitchen) This deficient practice had the potential to FSM/Designee will monitor affect 40 residents in the Assisted Living sanitizing area. solution stock weekly x 12 weeks. FSM/ Designee will also monitor sanitation cleaning buckets as well as Findings include: the sanitizer in the 3 compartment sink 2 times a day for 2 weeks and 1. Initial tour of the kitchen began on then 1 time a day for 2 weeks. 5/9/11 at 9:20 A.M. Cook #1 was Random checking of sanitizing levels will be done by FSM/Designee for observed to take a cloth from the bucket another 5 months. Results will be on the counter and wipe off the food prep brought to QA monthly for review table. Cook #1 took the container of test and recommendations if needed. strip paper, labeled "Phydration" and Completion Date 6-10-2011 stuck the orange colored paper in the

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Facility ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			î î			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155723	B. WIN			05/17/2011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER	-			ALAXY DR	
RIVER P	OINTE HEALTH CA	MPUS		1	VILLE, IN47715	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
1110		· · · · · · · · · · · · · · · · · · ·	+	1110	The dishwasher has been check	
	bucket of solution being used. The paper was held in the solution under 5 seconds.				the appropriate vendor to ensure	
					proper temperature can be	
		ip was removed, the			maintained for sanitation of our	
		ne same orange color as			dishes.	
	prior to the strip being placed in the				Completion Date 6-10-2011	
	solution. The res	sult was read by Cook #1			A 11 12 / 201 1	
	as 100 PPM (parts per million). He indicated this bucket of solution had been poured 2 1/2 hours ago and the level of sanitation solution should be between 100 and 200 PPM.				All dietary staff have been	and
					in-serviced on the proper wash rinse temperatures for the dish	anu
					machine and who to call for	
					assistance if temperatures are to	00
					low.	
					Completion Date 6-10-2011	
	On 5/11/11 at 9:2	25 A.M., Dishwasher #1				
	was interviewed				The yellow pudding like substa	nce
		k. He indicated the first			that was unlabeled was thrown away. The roast type ham in th	
					refrigerator that was dated 5-5-2	
		papy water for soaking			was also thrown away. The roa	
		I sink was the rinse sink			beef that was partially opened a	
		is where staff filled			unlabeled was thrown away. The	
		h the sanitizing solution.			turkey that was opened and und	
		s observed to have soapy	was thrown away. The bologna that			
	water in it with v	rarious cooking pans in it,			was in the resealable package at	nd
		f the water. The second			had the date that had been torn through was thrown away. The	
	sink was also fill	ed with clear water as			vegetable soup that had no labe	l l
	well as the third	sink, also filled with			also thrown away. The reddish	
	clear liquid. Disl	hwasher #1 explained			of liquid under the meat tray on	the
	1 -	is dispensed by a hose			floor was cleaned and sanitized	
		ected to a bottle of			appropriately.	
		ng the bottle of sanitizer			The begins of frage1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	ha
		s there were dish racks			The bag of frozen unlabeled fish thrown out of the freezer. The	
					racks in the refrigerator that we	•
	stacked up in front of it. Upon request, Dishwasher #1 was asked to test the strength of the sanitizer level in the 3rd				moved to get to the freezer had	
					that spilled on the floor of the w	- 1
					in refrigerator as they were mov	/ed.
		e test strips, labeled			It was immediately cleaned up.	
	Phydration, and t	took the orange strip of				

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155723	B. WING		05/17/2011		
			STREET	ADDRESS, CITY, STATE, ZIP CODE	•		
NAME OF I	PROVIDER OR SUPPLIER		3001 G	ALAXY DR			
RIVER P	OINTE HEALTH CA	MPUS	EVANS	SVILLE, IN47715			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	1	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	1 ^ ^	t in the 3 compartment		The bowl of shrimp that was us and unlabeled was thrown out.	ndated		
	sink. He indicate	ed he was to hold the		and unlabeled was thrown out.			
	strip in the water	for 10 seconds. When		Plastic wrap was ordered and			
	he removed the t	est strip, it was the same	quantity and availability will be				
	orange color as v	when he removed it from		maintained by the FSM/ Desig			
	the dispenser. D	ishwasher #1 indicated		Food on the speed racks will be	e		
	_	n sanitizer." When the		covered with plastic wrap.			
	1 *	was followed along the		Completion Date 6-10-2011			
	1 ^ ~	stacked dish racks, an		A 11 1:	1		
	1	der was observed. He		All dietary staff will be in-serv on proper food storage procedu			
				food in the refrigerators as wel			
	indicated someone had "gone to get more"			the freezers. The dietary staff			
	sanitizing solution	on.		also be in-serviced on proper			
				handling and usage of leftover	foods.		
		P.M., a copy of the May		Completion Date 6-10-2011			
		er Temp (temperature log)					
	was received from	m the Administrator.		FSM/ designee will monitor th			
	This form had di	shwasher temperatures		refrigerators and freezers daily months to ensure proper storag			
	documented for 6	each of the 3 meals a day		food and leftovers is being don			
	to date. Of the 3	6 rinse temperatures		The results of this monitoring			
	logged, 8 were d	ocumented to be below		forwarded to the QA committe			
	180 degrees Fahi			further recommendations if nee	eded.		
		ged from 170 - 179		Completion Date 6-10-2011			
	degrees Fahrenhe	~					
		√16.		All unpasteurized were thrown			
	On 5/16/11 at 12	P.M., the Regional		Staff was in-serviced on the poserving unpasteurized eggs.	ncy of		
		,		Completion Date 6-10-2011			
	1 * -	RR] was interviewed. He		50mpion 500 0 10 2011			
		se temperature of the		FSM/Designee will continue to)		
		ld be at least 180 degrees		monitor food orders to ensure to			
		ndicated that kitchen		availability of pasteurized eggs	to		
	staff "have not b	een educated enough to		cook.			
	be aware of requ	ired temperatures."		Completion Date 6-10-2011			
				Thermometers have been place	din		
	2. During initial	tour of the kitchen, on		all refrigerators and freezers pe	I		
	I -	M., Cook #2 entered the		policy. All dietary staff includ	I		

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155723	B. WIN	G		05/17/2011
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE	
				1	ALAXY DR	
RIVER P	OINTE HEALTH CA	MPUS		EVANS	VILLE, IN47715	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	_	tor. He lifted a single			our regional representative have in-serviced on where the	e been
	_	yellow pudding like			thermometers are located as we	11 ac
	food from the shelf. This bowl was not				safe temperature ranges for the	ii as
	labeled. Cook #2	2 was unable to identify			freezer and refrigerators. Each	
	what was in the bowl. A roast type ham				dietary staff member has been	
	was observed on	one of the shelves. Cook			in-serviced on where to record	daily
	#2 indicated the	date on the ham (which			temps and who to contact if	
	he identified to b	e approximately 3			temperatures are not within rang	-
		te of 5/5/11. Cook #2			The in-service included the disp of food that ever encounters out	
	* ′	n should have been			range temperatures.	1 01
		8/11, as they keep			Completion Date 6-10-2011	
		dous foods for only 3			•	
		of roast beef, identified			All food in the stand up freezer	was
		approximately 3-4			disposed of. A freezer log was	,
	=	ially covered with plastic			placed on the outside of the star freezer.	nd up
		-			Maintenance was called to chec	ek the
	•	ndicated this roast beef			temperature problem in the free	
	_	te. A package of turkey			The freezer was fixed.	
	` ′	was opened but not dated			Completion Date 6-10-2011	
		opened. An opened				
		na was also observed.			All equipment has been pulled of and the floors have been cleane	
		ealable package but was			including the edges.	u
		hen it was opened and			Completion Date 6-10-2011	
		n the package was unable			F	
	to be read as it ha	nd been torn through. A			The hand washing sink has been	
	sheet pan was ob	served in the walk in			thoroughly cleaned and the tras	
	refrigerator with	an uncut baked cake in it.			removed with a new one placed	· 1
	The cake was not	t covered or dated. A 15			the hand washing sink. All spar on the walls have been wiped cl	
	quart container w	as observed with			All shelves have been cleaned a	
	-	it. This container was			well as a new microwave purch	
	-	1 indicated the soup had			and the old stained one thrown	
		day. A pool of a reddish			Completion Date 6-10-2011	
	_	ance was observed			T1	
		of a leg of one of the			The staff have been in-serviced	on
		lk in refrigerator. The			the proper way to keep trash contained and the trash overflow	wing
	sherres in the wa				contained and the trash overflow	·······b

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155723 05/17/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3001 GALAXY DR RIVER POINTE HEALTH CAMPUS **EVANSVILLE, IN47715** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE diameter of the pooled reddish liquid was in the trash can was taken out. **Completion Date 6-10-2011** at least 5 inches and was drying on the edges. Directly above the reddish pool, The staff have been in-serviced on was a case of beef, placed directly on the how to properly wash the floor mats metal shelving. in the dish room. They have also been in serviced on proper use of the three compartment sink and cross At 9:45 A.M., the walk in freezer was contamination. observed. A bag of frozen, unbreaded Completion Date 6-10-2011 fillet type fish was observed. The fish was in a bag, which Cook #2 identified as All staff will be in-serviced on the washing of the hand sink as well as not having a date, and observed that the the 3 compartment sink. bag was not sealed, but had a hole, at least Completion Date 6-10-2011 6 inches in diameter in the exposed side of the bag. The bag was not labeled as to Cleaning schedules have been posted its contents. and staff has been in serviced on their individual responsibilities for kitchen sanitation. At 1:30 P.M., Cook #2 indicated he was **Completion Date 6-10-2011** going to dispose of the fish fillets in the walk in freezer in the opened bag. Cook FSM/designee will monitor the #2 was in the walk in refrigerator and cleaning schedules daily x 6 months to ensure staff is performing assigned moved a standing, wheeled rack with duties. Audits will be forwarded to large uncovered, pans of red liquid in the QA committee for further review them. When Cook #2 moved the rack, the and recommendation as needed. wheel stuck and the pans of red liquid Completion Date 6-10-2011 spilled and spattered on the floor of the Staff has been in serviced on the use walk in refrigerator. of hair restraints in all kitchen food prep areas. Hair restraints have been A covered bowl of cooked shrimp was placed outside the dining room so observed at 2 P.M. on the bottom shelf of staff other than dietary that need to enter the kitchen may do so with a the walk in refrigerator. This shrimp was hair net in place. not dated. The bowl had water in it and Completion Date 6-10-2011 that pan was placed in a pan with ice in it. The temperature of the shrimp was 30 Overall sanitation will be monitored degrees. Cook #1 indicated the pre by the FSM/Designee on a weekly

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR' 00 COMPLETE					
AND PLAN	OF CORRECTION	155723	A. BUI	LDING	00	05/17/2	
		100720	B. WIN			03/17/20	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ALAXY DR		
RIVER P	OINTE HEALTH CA	MPUS			VILLE, IN47715		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	cooked shrimp ha	ad been thawed in the			basis through a sanitation score		
	refrigerator in the	e package yesterday and			checklist. Sanitation checks wi completed weekly for 6 weeks		
	when they were thawed, water was added. On 5/10/11 at 8:20 A.M., the reddish liquid observed pooled at the base of the shelf leg in the walk in refrigerator was				then months thereafter for 10 m		
					with the results being forwarded		
					the QA committee for further re		
					and recommendations as needed	d.	
					Completion Date 6-10-2011		
	again observed.	The reddish puddle was					
	approximately 6 inches in diameter. At 8:20 A.M. on 5/10/11, Cook #3 was						
	interviewed regarding ham in the walk in						
	refrigerator. She	indicated the chunk of					
	ham was about 3	pounds. The cut ham					
	was covered with	n plastic wrap but was not					
	dated. She indicate	ated the ham had been					
	opened yesterday	7. She removed the ham					
	from the refrigera	ator and placed it in a					
	plastic container	and dated it.					
	· ·	#3 toured the walk in					
	_	ned bag of frozen fillet					
	J - 1	ed in the walk in freezer.					
	Cook #3 threw th	ne opened bag of frozen					
	fish away.						
	On 5/11/11 at 8:3	30 A.M., the walk in					
		observed. The reddish					
	1 -	around the same leg of					
	_	eved on 5/9/11 and					
	5/10/11.						
	- · - • · •						
	On 5/11/11 at 11:	:45 A.M., the RR					
		of the undated policy and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	e survey pleted /2011	
	PROVIDER OR SUPPLIER		STREET / 3001 G	ADDRESS, CITY, STATE, ZIP O ALAXY DR VILLE, IN47715	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	procedure for "For properly stored to preserve flavor, in appearance." The was not limited the is covered, dated permit air circular perishables such in a refrigerator and dated until used. The refrigerated immore 72 hours or frozen freezer are wrapped wrapping or place to prevent freezer and dated. On 5/11/11 at 3:0 toured with the Formula was asked by of carrot salad word walk in refrigeration uncovered. Cook have any plastic was then covered pans. On 5/12/11 at 11 interviewed. He fallen short on gittools they need to inservicing had be serviced to the property of the fallen short on gittools they need to inservicing had be serviced.	ood and supplies shall be to keep foods safe and mutritive value and the procedure, included but to, the following: "Food and stored loosely to attionPrepared aspuddingsare stored and covered, labeled and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MULTIPLE A. BUILDING B. WING	00		e survey pleted /2011	
	PROVIDER OR SUPPLIER		3001	ET ADDRESS, CITY, STATE, ZIP GALAXY DR NSVILLE, IN47715	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	utilized in an app to aid in controll was undated. The was not limited to "Leftovers shoul abeledas soon finishedleftover covered so they approof. They are dateThe Dining cook checks for an additional determines have a sound determines have a sound eggs we indicated these efform a local group of eggs and the effect of the indicated they order in on that counters. No mar these eggs. At the two of the shelled cracked them and skillet. He then is	eftover foods will be propriate and safe manner ing waste." This policy be procedure included, but oo, the following: all be covered, dated, as meal service is rs which are frozen are air-tight and moisture labeled with item and generated Service Manager or leftovers each morning how to use them tour of the kitchen on M., the walk in observed. Five boxes of ere observed. Cook #2 ggs had just been bought bery, as they had run out ggs were not pasteurized. It was a safe of the cook was a safe of th				

l	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COME 05/17/	LETED
	PROVIDER OR SUPPLIER		3001 G	ddress, city, state, zip co ALAXY DR VILLE, IN47715	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	was interviewed he just cooked with He stated the yol Cook #1 indicated run out of eggs and indicated he thou cooked over meet them. At this time interviewed. Show unpasteurized egg Cook #1 then threeggs out. On 5/11/11 at 2 If copy of the Polica and sanitary hand employed during policy was undated but was not limit "only pasteurized On 5/12/11 at 11 interviewed. He should be pasteut were in a "situatistore and bought eggs."	itchen. At that time he He indicated the eggs ere not pasteurized and h the whites to a medium. ks were not hard cooked. Ed that sometimes they and buy them. He aght if the whites were lium it was OK to serve the Cook #3 was the indicated she thought ags had to be cooked hard. The medium cooked P.M., the RR provided a try and procedure for "safe dling of food will be a food production." This and. This policy included, the do, the following: I raw eggs are served." A.M., the RR was indicated that all eggs rized. He indicated they on where they ran to other (non pasteurized)				
	5/9/11 at 9:45 A. was observed. C	M., the walk in freezer cook #2 was looking for to read the current				

l	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	li i	E SURVEY PLETED (2011
	PROVIDER OR SUPPLIER		3001 G	ADDRESS, CITY, STATE, ZIP CO ALAXY DR VILLE, IN47715	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	1 ^	ok #2 was unable to find the walk in freezer.				
	Log" was observe walk in refrigeral had no date for the but was completed the month. The entry for the walk At 9:50 A.M., the					
	up freezer was redegrees (Fahrenla 3 gallon drums of containers had a sealing the ice or fourths of the paseparated from the cream. The containers had a sealing the ice cream was observed to mushy ice cream edge of the containers was observed to mushy ice cream edge of the containers was observed to mush ice cream was observed to mush ice cream was observed to mush ice cream was observed to contain toward the center ice cream was observed to mush ice cream was observed to contain the	temperature to the stand ead by Cook #2 as 31 neit). There were 5 large, if ice cream. One of the paper lid, which was not eam closed. Three per lid round was ne edge, thus exposing ice niner had approximate 1/3 missing. The ice cream be melting, with soft observed from the inside niner, at least 1 inch in r of the container. Fluid oserved in the center of ook #2 threw this drum by. All 5 drums of ice enough to be able to be				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MULT A. BUILDIN B. WING		00	(X3) DATE S COMPL 05/17/2	ETED	
	PROVIDER OR SUPPLIER		3	001 GA	DDRESS, CITY, STATE, ZIP CODE LAXY DR ILLE, IN47715		
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRE	D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
IAG	pushed in when of the container. unopened contain opened with the observed as above observed at least edge of the container. This shouldn't be freezer was in determined while waiting for Cook #2 began of freezer. He remaining drums 48 count "magic approximately 1 (when pushed or magic cup, then from the edges of cream pies; 2 caservings, of might count case of 4 calso removed from the edges of cartons were ablusides when felt. food items should carton of mighty the back of the first solid when the callo:05 A.M., the to the walk in free removed from the carton of the carton of the callo the walk in free removed from the callo the walk in free removed from the callo the callo the walk in free removed from the callo the callo the walk in free removed from the callo the callo the walk in free removed from the callo the callo the callo the walk in free removed from the callo the	couched from the outside One of the other mers of ice cream was same degree of melting we, with mushy ice cream 1 inch in from the inside miner. Cook #2 indicated e" and thought maybe the effrost mode. He notified man of the freezer. or the maintenance man, emptying the stand up eved the following: 4 s of ice cream; a case of cup" food items, with magic cups missing mone of the lids of the melted substance emerged of the lid); 3 pre packaged we of 50 count, 4 ounce my shakes and one 75 munce mighty shakes was we the freezer. These we to be pushed on the Cook #2 indicated the dn't be soft. A single what shake was removed from meezer and was frozen marton was touched. At mabove items were moved meezer on a cart. Also me freezer were 3 boxes of metal of the outside metal of the outside metal of the outside man of the inside man of the inside man of the freezer. The maintenance man, man of		AU			DATE

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	ULTIPLE CO	INSTRUCTION 00	(X3) DATE : COMPL	
THIE TEAM	or conduction	155723	A. BUII			05/17/2	
		100720	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/11/2	
NAME OF F	PROVIDER OR SUPPLIER				ALAXY DR		
RIVER P	OINTE HEALTH CA	MPUS		1	VILLE, IN47715		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
		nd 4 prepackage loaf					
	pound cakes. An angel food cake was						
		one, one inch slice					
	_	gel food cake was not					
	1 * *	red, was not dated and					
	was also observe	d to be soft.					
	On 5/9/11 at 11 A.M., a copy of the "Refrigerate						
	Temp (temperature) log was received from the						
	This is the log which hung in the kitchen on the						
	refrigerator/freezer. This log was completed for						
	The "month" area was left blank. The categorie						
	form included the	e following: "walk in refrigera					
		refrigerator; milk cooler." Doc					
		nis form of an area to document					
	freezer temperatu						
	P						
	On 5/9/11 at 1:32	2 P.M., the temperature of					
	the stand up freez	zer was observed to be 8					
	degrees F. The f	reezer was empty at the					
	time.						
	On 5/11/11 at 11:	:45 A.M. a copy of the					
	policy and proceed	dure for "Food and					
	supplies shall be	properly stored to keep					
	foods safe and pr	reserve flavor, nutritive					
	value and appear	ance." This policy was					
	undated. The pr	ocedure included, but					
	was not limited to	o, the following:					
		are placed in every					
		so as to be easily visible					
	_	in the upper third part of					
	the front of the st						
		ll be recorded on the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155723		(X2) MU A. BUILI B. WING	DING	nstruction 00	(X3) DATE S COMPL 05/17/2	ETED	
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE ALAXY DR VILLE, IN47715		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	at 0 degrees F (F belowTempera	age temperatures will be					
	in freezer temper all and/or any re	was lacking of the reach rature being monitored at efrigerator and/or freezer eratures monitored twice					
	On 5/11/11 at 2:50 P.M. a tour was conducted with the Facilities Regional Representative (Rep.) (RR). In the main dining room, located directly off the kitchen, the RR was unable to locate log, documenting the temperature was being monitored in this refrigerator.						
		e walk in freezer was RR. He was unable to ter.					
	·	e milk cooler was toured was unable to find a he milk cooler.					
	indicated on the Dietary staff left P.M. She indica	P.M., the Administrator evening of 5/8/11, the the department about 10 ted when the dietary staffing of 5/9/11, the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00		ESURVEY LETED 2011	
	PROVIDER OR SUPPLIEF		3001 G	ADDRESS, CITY, STATE, ZIP GALAXY DR SVILLE, IN47715	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	temperature in the degrees Fahrenh was informed the freezer had not devening of 5/8/1 reach in freezer, increased temperature in freezer, increased temperature in freezer, increased temperature food items, especially and appliances. The flooring of the to have scattered food items, especially appliances. The only hand we with the following was a small brush seeds on it. The observed to have residue scattered brownish residue top edges of the the edges of the sink was observed.	ne reach in freezer was 60 eit. She indicated she at the door to the reach in closed properly the 1, the fan froze up to the thus leading to the rature. I tour of the kitchen, on .M., the following was he kitchen was observed a dust, debris and bits of cially along the wall d the legs of tables and wash sink was observed ng: in the base of the sink h and a sponge with basin of the sink was e brownish areas of a throughout. The same e was observed along the faucet fixture and along sink. The wall behind the ed to have various	1	CROSS-REFERENCED TO THE		1
	the wall. The ha next to a covered trash can. The li heavily laden wi	and wash sink was located and, foot pedal operated at to this trash can was th various spatters of . The trash can was				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00		TE SURVEY MPLETED	
		155723	A. BUILDING B. WING		05/1	7/2011
	PROVIDER OR SUPPLIE		3001 G	ADDRESS, CITY, STATE, ZIP ALAXY DR WILLE, IN47715	CODE	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	<u> </u>		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF C	N SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	1	er. The walls on the back				
		rash can were also laden				
		dried substances, from				
	chest height on t	he wall down.				
	The open shelf u	inderneath the sink in the				
	_	s observed. This shelf				
	1	ckets of sanitizer solution				
	on it. Througho	ut the shelf were areas of				
	1	dark black brown sticky residue.				
	The microwave was observed to have					
	1 -	a light substance on the				
	I .	ven. When opened, the				
		rowave was observed to				
	1	substance covered the				
	I .	oven bottom, extending lge at least 2 inches.				
		vere also observed				
	1 -	nicrowave. This black				
	_	ble to be scraped off.				
	1	ed trash can was				
	1	P.M. in the cooking area				
	and the dishwash	•				
	overflowing and	without a iid.				
	On 5/10/11 at 8:	20 A.M., the hand wash				
	sink was observe	ed again. The small brush				
	remained in the	sink basin as observed on				
	5/9/11. The con	dition of the sink, walls				
	and covered tras	h can also remained the				
	same as observe	d on 5/9/11.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723		(X2) MULTIPLE CO A. BUILDING B. WING	00	CON	TE SURVEY SPLETED 7/2011		
NAME OF PROVIDER OR SUPPLIER RIVER POINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 3001 GALAXY DR EVANSVILLE, IN47715				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
IAU	On 5/10/11 at 8:2 condition, shelf of microwave rema observed on 5/9/ On 5/11/11 at 9 again observed. outside and the coinside remained initial tour. On 5/11/11 at 9:3 sink was again or remained in the sinitially on 5/9/1 sink, walls and cremained the same of the same of the sink in remained the same at 9:20 A.M. On 5/11/11 at 11 was observed in Dishwasher #2 prom the floor and dish work space was laying flat at water nozzle with and began scrubil This is the same	20 A.M., the floor condition and the ined the same as 11. A.M., the microwave was The dried spatters to the lark substance to the as observed on 5/9/11 on 10 A.M., the hand wash bserved. The small brush sink basin as observed 1. The condition of the overed trash can also he as observed on 5/9/11. 10 A.M., the open shelf the food prep area he as observed on 5/9/11 :15 A.M., Dishwasher #2	IAG			DATE	

i '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723	A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/17/2	ETED
		100720	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/11/2	
NAME OF PROVIDER OR SUPPLIER				1	ALAXY DR		
RIVER POINTE HEALTH CAMPUS				EVANS'	VILLE, IN47715		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		ΤE	COMPLETION DATE
IAG	<u> </u>	th the dishwasher. He		IAG			DATE
	, ,	abber floor mat up and					
		econd compartment of the					
	1 ~	ent sink, where there was					
	_	bber floor mat rolled up.					
	He then began so	crubbing the dish area					
		with a brush/broom.					
	At 11:40 A M o	n 5/11/11, Dishwasher #2					
		vater into the second					
		the 3 compartment sinks.					
	1 ^	had been replaced to the					
		er #1 was interviewed.					
		y clean the sink twice a					
		cleaned right after					
		dicated he had not					
	cleaned the 3 cos	mpartment since after					
	breakfast.	•					
	At 12:15 P.M. o	n 5/11/11, a pan was					
		g in the 2nd compartment					
	of the 3 compart	-					
	l and a compart						
	At 12:15 P.M., I	Dishwasher #1 was					
	interviewed. He	indicated they were out					
		tion. He indicated they					
	had some for bre	eakfast but were out at					
	that time.						
	At 12:20 P.M t	he RR returned with					
	· ·	and indicated, "this will					
	be hooked up rig						
	A. 10 00 D. 1. D	1 1 //2					
	At 12:20 P.M. D	ishwasher #2 was					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155723			A. BUILE		00	COMPL 05/17/2	ETED
		100723	B. WING	_		05/17/2	UII
NAME OF	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
RIVER POINTE HEALTH CAMPUS					ALAXY DR VILLE, IN47715		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	interviewed. He washed any of the today. On 5/11/11 at 4:5 interviewed. The and the AFSM me sanitation and he on 5/12/11 at 9:4 toured with the Resink remained as 5/10/11 and 5/11, the brush, lying it was probably use fingernails with. On 5/12/11 at 11 interviewed. He to locate any concleaning schedule indicated the last schedule was don on 5/12/11 at 11 "The handwashir and sanitized on to defined proceed This policy was dereceived from the review. Docume	indicated he had not e 3 compartment sinks 35 P.M., the RR was e RR indicated the FSM conitored kitchen monitored them. 45 A.M., the kitchen was e R. The condition of the observed on 5/9/11, /11. The RR indicated in the base of the sink, ed to clean employees' 230 A.M., the RR was indicated he was unable inpleted documented es for the kitchen. He completed cleaning ine before the FSM left. 245 A.M., the Policy for ing sink will be cleaned a routine basis according dures" was reviewed. In the time of contation was lacking as to of "routine basis"		TAG	DEFICIENCY)		DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU COMPLET		
155723			A. BUI	LDING	00	05/17/201	
		155725	B. WIN			03/11/20	11
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE ALAXY DR		
RIVER POINTE HEALTH CAMPUS					VILLE, IN47715		
					VILLE, IIVII I I I		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	, i	LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		TE .	DATE
	On 5/12/11 at 12	:20 P.M., blank copies of					
		and monthly cleaning					
	"	eceived. Daily Tasks					
		re not limited to, the					
	· · · · · · · · · · · · · · · · · · ·	ell sink, each use; hand					
	sink; juice machi						
	· ·	rs sweep/mop; work table					
	l '	tables serving area."					
	6. On initial tour	of the kitchen, on 5/9/11					
		kitchen was observed in					
		nner: The one main					
		kitchen was from the					
	l *	n. The one main walk					
		nt of the kitchen to the					
	l *	tly by the food prep table					
	· ·	rep/cook area was					
	1	n the kitchen off to the					
	1	valk way. Staff were					
		time, to walk into the					
	· ·	nair restraint on and					
		ets" (with residents' food					
	_	on the side of the ice					
	l '	e machine was also					
		walkway from the shorter					
	side of the food p	-					
	F	F					
	On 5/9/11 at 10:1	15 A.M., the					
		as observed walking into					
		out a hair restraint in					
		ne she walked by the food					
	1 *	vered chicken breasts					
		iter being prepared.					
	ere on the coun	orne brobaroa.					

I .		IDENTIFICATION NUMBER: A. B		ULTIPLE CO	INSTRUCTION 00	(X3) DATE SUF COMPLET	
				LDING		05/17/201	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					ALAXY DR		
RIVER POINTE HEALTH CAMPUS				EVANS	VILLE, IN47715		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF		re C	COMPLETION DATE
	On 5/9/11 at 12 P.M., Physical Therapy						5.112
		erved inside the kitchen					
		air restraint on. Meal					
		in progress at the time.					
		5 A.M., the SSD (social					
	/	entered the kitchen					
		raint on. She walked in					
		the kitchen, through the					
	• •	by the food prep area and					
	walked to the bac	ck of the kitchen.					
	On 5/11/11 at 8:2	20 A.M., LPN #1 entered					
		out a hair restraint on. He					
		r ticket, entered the					
		er to the ice machine					
		and stuck the order					
	ticket on the side						
		A.M., the Maintenance					
	-	mpanied by an outside					
		ralked through the main en. The service worker					
		hair restraint on. The					
	1	nair restraint on. The pervisor was observed					
	with a ball type c						
	with a ball type c	ωρ on.					
	On 5/12/11 at 11:	:30 A.M., the RR was					
		indicated anyone going					
		en area should have a					
	_	He also indicated the					
	food prep area w	as along the only path					
	through the kitch	en from front to back.					

l	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COME - 05/17/	LETED
NAME OF PROVIDER OR SUPPLIER RIVER POINTE HEALTH CAMPUS			3001 G	ADDRESS, CITY, STATE, ZIP CO ALAXY DR VILLE, IN47715	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	policy and proce Services Departr appropriately and was received fro included, but wa following: "The requirements reg will wear hairned covers the hair was serving food." The Census Sheet, pon 5/9/11 at 11:00 a	245 A.M., the undated dure for "Nutrition ment employees will dress d practice good hygiene" m the RR. The policy is not limited to, the organization has strict garding hair: Employees is that COMPLETELY while in the kitchen or an indicated there were 40 in the Assisted Living Units in initial level of care].				